

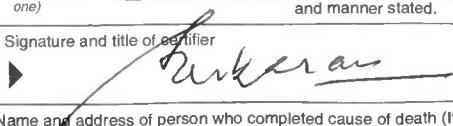
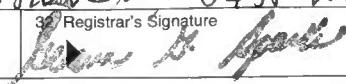
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 12001

1- For State Registrar

Physician /Medical Examiner		1. Decedent's Name (First, Middle, Last) Dorothy E. O'Neill					2. Date of Death Month April Day 12, 2007 Year	3. Time of Death 4:50 A M	
Funeral Director		4a. Facility Name (If not institution, give street and number) St. Martin's Home			4b. City, Town, or Location of Death Catonsville			4c. County of Death Baltimore	
To Be Completed by Funeral Director		5. Social Security Number 090-03-7197	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 90 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) Nov. 20, 1916	9. Birthplace (State or Foreign Country) New York	
		Usual Residence of Decedent 10a. State Md.			10b. County Baltimore			10c. City, Town or Location Catonsville	
		10e. Street and Number 425 Greenlow Road			10f. Zip Code 21228			10g. Citizen of What Country? USA	
		11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White
		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) 0 Asst. Librarian			16b. Kind of Business/Industry State University	
		17. Father's Name (First, Middle, Last) Elmer Megee			18. Mother's Name (First, Middle, Maiden Surname) Adrien Lancer				
		19a. Informant's Name/Relationship (Type, Print) Michael H. O'Neill / Son			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 106 Wye Acres Road, Queenstown, Maryland 21658				
		20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Meadowridge Mem. Pk.			Date 4/16/07	
		21. Signature of Funeral Service Licensee 			22. Name and Address of Facility Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229			20c. Location - City or Town, State Elkridge, Maryland	
Physician /Medical Examiner		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) STROKE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Hypertension							
Medical Certification: To Be Completed by Physician/Medical Examiner		23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown 23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____ <input type="checkbox"/> Unknown							
		23d. Date of delivery Month Day Year							
		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Seizure disorder Cancer colon							
		23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown							
		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No							
		25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide							
		28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No							
		28d. Describe how injury occurred							
		28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)							
		28f. Location (Street and Number or Rural Route Number; City or Town, State)							
		29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
		29b. Signature and title of certifier 							
		29c. License number D 21649 29d. Date signed (Month, Day, Year) April 12, 2007							
		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SANDRA BASKERAN 3455 Wilkens Av. Baltimore MD 21229							
		31. Date filed (Month, Day, Year) APR 16 2007 32. Registrar's Signature 							

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division or Vital Records, P.O. Box 68760, 

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State Registrar

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 12002

1- For
State
Registrar

**Physician
/Medical
Examiner**

**Funeral
Director**

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Physician
/Medical
Examiner**

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

		1. Decedent's Name (First, Middle, Last) BRENDA E. OVERICK						2. Date of Death Month April Day 12 Year 2007	3. Time of Death 4:28 A M	
		4a. Facility Name (If not institution, give street and number) Franklinwoods			4b. City, Town, or Location of Death Rosedale			4c. County of Death Baltimore		
		5. Social Security Number 030-30-8256	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 66 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Hours	8. Date of Birth (Month Day Year) Oct. 25, 1940	9. Birthplace (State or Foreign Country) Massachusetts		
		Usual Residence of Decedent 10a. State MD 10b. County Baltimore			10c. City, Town or Location Rosedale			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
		10e. Street and Number 9200 Franklin Square Drive			10f. Zip Code 21237			10g. Citizen of What Country? USA		
		11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White	
		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Truck Driver			16b. Kind of Business/Industry Lafarge Industrial Company		
		17. Father's Name (First, Middle, Last) Richard Gendron			18. Mother's Name (First, Middle, Maiden Surname) Lorraine Beaudin					
		19a. Informant's Name/Relationship (Type, Print) Lorraine Cairns-daughter			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7922 Dalesford Road-Parkville, Maryland 21234					
		20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory, mortuary, other place) EVANS FUNERAL CHAPEL AND CREMATION-BelAir			Date 4-14-07	20c. Location - City or Town, State Forest Hill, MD	
		21. Signature of Funeral Service Licensee <i>Condrie Lynn Taddeo</i>			22. Name and Address of Facility EVANS FUNERAL CHAPEL AND CREMATION SERVICES			8800 Harford Road Parkville, MD 21234		
		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)			23b. Due to (or as a consequence of): <i>Lung Cancer</i>			Approximate Interval Between Onset and Death		
		23c. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last			23d. Due to (or as a consequence of):					
		23e. Due to (or as a consequence of):			23f. Due to (or as a consequence of):					
		23g. Due to (or as a consequence of):			23h. Due to (or as a consequence of):					
		23i. IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown			23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year		
		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23e. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
								23f. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
								23g. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		
		25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred			
				28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)			
		29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
		29b. Signature and title of certifier <i>Mohammed Rahama</i>		29c. License number D45475			29d. Date signed (Month, Day, Year) 4-13-07			
		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Mohammed Rahama								
		31. Date filed (Month, Day, Year) APR 16 2007		32. Registrar's Signature <i>John B. Hale</i>						

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 12003

1 - For State Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Elizabeth Catherine Piercy					2. Date of Death Month 04 Day 12 Year 2007	3. Time of Death 08:15 aM	
	4a. Facility Name (If not institution, give street and number) Augsburg Lutheran Home			4b. City, Town, or Location of Death Baltimore		4c. County of Death Baltimore		
Funeral Director	5. Social Security Number 214-16-9235	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 85 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days Hours Min.	8. Date of Birth (Month Day Year) 10/03/1921	9. Birthplace (State or Foreign Country) Maryland	
To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State MD 10b. County Baltimore 10c. City, Town or Location Baltimore 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
	10e. Street and Number 6825 Campfield Road Apt H			10f. Zip Code 21207		10g. Citizen of What Country? U.S.A.		
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: White			14. Race - American Indian, Black, White, etc. Specify: White		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Bookkeeper			16b. Kind of Business/Industry Office Supply		
	17. Father's Name (First, Middle, Last) John Streckfus				18. Mother's Name (First, Middle, Maiden Surname) Mabel Bruns			
	19a. Informant's Name/Relationship (Type, Print) E. Christian Piercy			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 East University Pkwy Unit 1411 Balto, MD 21218				
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) Moreland Memorial		20b. Place of Disposition (Name of cemetery, crematory or other place) Moreland Memorial		Date 4/18/07	20c. Location - City or Town, State Baltimore, Maryland		
	21. Signature of Funeral Service Licensee Alexandria Bates				22. Name and Address of Facility Leonard J. Ruck, Inc. 5305 Harford Road, Baltimore, MD 21214			
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							
	<p>a. Metastatic Pilomyosarcoma Due to (or as a consequence of):</p> <p>b. _____ Due to (or as a consequence of):</p> <p>c. _____ Due to (or as a consequence of):</p> <p>d. _____</p>							
	Approximate Interval Between Onset and Death							
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown			23c. If yes, outcome pf pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown <input type="checkbox"/> Other (specify) _____		23d. Date of delivery Month Day Year -		
Medical Certification: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. _____ _____ _____							
	23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown							
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
	26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DCA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) _____							
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred		
	28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)							
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
	29b. Signature and title of certifier Dorothy Seay			29c. License number DO053337		29d. Date signed (Month, Day, Year) 4-12-07		
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dorothy Seay, MD 25 Main St. Ste. 200 Reisterstown, MD 21136							
State Registrar	31. Date filed (Month, Day, Year) APR 16 2007		32. Registrar's Signature Leanne B. Speller					

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 12004

1 - For State Registrar

Physician /Medical Examiner <div style="font-size: small; margin-top: 10px;">Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.</div>	<p>1. Decedent's Name (First, Middle, Last) STELLA LOUISE PERRY</p> <p>4a. Facility Name (If not institution, give street and number) FUTURECARE</p> <p>5. Social Security Number 217-50-4886</p> <p>6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F</p> <p>7. Age (In yrs. last birthday) Yrs. 59</p> <p>4b. City, Town, or Location of Death BALTIMORE</p> <p>8. Date of Birth (Month, Day, Year) FEB. 27, 1948</p> <p>2. Date of Death Month Day Year APRIL 10, 2007</p> <p>3. Time of Death 10:30 A M</p> <p>4c. County of Death NC</p>						
Funeral Director	<p>4a. Facility Name (If not institution, give street and number) FUTURECARE</p> <p>5. Social Security Number 217-50-4886</p> <p>6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F</p> <p>7. Age (In yrs. last birthday) Yrs. 59</p> <p>4b. City, Town, or Location of Death BALTIMORE</p> <p>8. Date of Birth (Month, Day, Year) FEB. 27, 1948</p> <p>2. Date of Death Month Day Year APRIL 10, 2007</p> <p>3. Time of Death 10:30 A M</p> <p>4c. County of Death NC</p>						
To Be Completed by Funeral Director	<p>10a. State MD</p> <p>10b. County BALTIMORE</p> <p>10c. City, Town or Location BALTIMORE</p> <p>10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>10e. Street and Number 1918 DRUID HILL AVE.</p> <p>10f. Zip Code 21217</p> <p>10g. Citizen of What Country? USA</p>						
Physician /Medical Examiner <div style="font-size: small; margin-top: 10px;">To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit slip.</div>	<p>11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced</p> <p>12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:</p> <p>13. Was Decedent of Hispanic Origin? (Specify Yes or No) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: Specify: BLACK</p> <p>14. Race - American Indian, Black, White, etc.</p> <p>15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4 or 5+) 4</p> <p>16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) DEVELOPMENT ASSISTANT</p> <p>16b. Kind of Business/Industry CHARITY ORGANIZATION</p> <p>17. Father's Name (First, Middle, Last) NATHANIEL CLIFTON, SR.</p> <p>18. Mother's Name (First, Middle, Maiden Surname) CARRIE NICHOLSON</p> <p>19a. Informant's Name/Relationship (Type, Print) WANDA INEZ DOMINIC/DAUGHTER</p> <p>19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1918 DRUID HILL AVE., BALTIMORE, MD 21217</p> <p>20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) KING MEMORIAL PARK</p> <p>20b. Place of Disposition (Name of cemetery, crematory or other place) KING MEMORIAL PARK</p> <p>20c. Location - City or Town, State 8710 DOGWOOD RD. WINDSOR MILL, MD 21244</p> <p>Date 04/14/2007</p> <p>21. Signature of Funeral Service Licensee Wesley Chavis</p> <p>22. Name and Address of Facility WESLEY CHAVIS, JR. FNRL. HM. 2007-09 EASTERN AVE., BALTIMORE, MD 21231</p> <p>23a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)</p> <p>23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown</p> <p>23c. If yes, outcome pf pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown</p> <p>23d. Date of delivery Month Day Year</p> <p>23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown</p> <p>23f. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Pneumonia</p> <p>23g. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>23h. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)</p> <p>26. Place of Death (Check only one) 4. Nursing Home</p> <p>27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide</p> <p>28a. Date of Injury (Month, Day Year) M</p> <p>28b. Time of Injury 1 □ Yes 2 □ No</p> <p>28c. Injury at Work? 1 □ Yes 2 □ No</p> <p>28d. Describe how injury occurred</p> <p>28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) At home</p> <p>28f. Location (Street and Number or Rural Route Number, City or Town, State) 9419 Common Brook Rd, Ste 200 Owings Mills, MD</p> <p>29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.</p> <p>29b. Signature and title of certifier Royce Hagan Jr, MD</p> <p>29c. License number D5625</p> <p>29d. Date signed (Month, Day, Year) April 13, 2007</p> <p>30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Royce Hagan Jr, MD 9419 Common Brook Rd, Ste 200 Owings Mills, MD</p> <p>31. Date filed (Month, Day, Year) APR 16 2007</p> <p>32. Registrar's Signature Rosemary B. Parker</p>						

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit slip.

Medical Certification: To Be Completed by Physician/Medical Examiner

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 12005

1- For State Registrar

Physician /Medical Examiner		1. Decedent's Name (First, Middle, Last) ESTHER PELOVITZ				2. Date of Death Month Day Year April 12 2007		3. Time of Death 1:20 PM		
Funeral Director		4a. Facility Name (If not institution, give street and number) Sinai Hospital of Baltimore				4b. City, Town, or Location of Death Baltimore		4c. County of Death N/A		
To Be Completed by Funeral Director		5. Social Security Number 213-26-1613		6. Sex 1 M 2 F	7. Age (In yrs. last birthday) 93 Yrs.	If Under 1 Year Months Days Hours Min. 	8. Date of Birth (Month, Day, Year) 04/30/1913		9. Birthplace (State or Foreign Country) WASHINGTON D.C.	
		Usual Residence of Decedent		10a. State MD		10b. County N/A		10c. City, Town or Location BALTIMORE		10d. Inside City Limits 1 Yes 2 No
		10e. Street and Number 7121 PARK HEIGHTS AVENUE #503				10f. Zip Code 21215		10g. Citizen of What Country? U.S.A.		
		11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No Specify:		14. Race - American Indian, Black, White, etc. WHITE		
		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 2 HOMEMAKER		16b. Kind of Business/Industry OWN HOME				
		17. Father's Name (First, Middle, Last) CHAIM LAPIDUS				18. Mother's Name (First, Middle, Maiden Surname) LEAH DAVIS				
		19a. Informant's Name/Relationship (Type, Print) SHELDON PELOVITZ / SON				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10801 SYMPHONY WAY - COLUMBIA, MD 21044				
		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) BNAI ISRAEL		Date 04/13/2007	20c. Location - City or Town, State BALTIMORE, MD			
		21. Signature of Funeral Service Licensee Scott M. Cutler				22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208				
Physician /Medical Examiner		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Pneumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown								Approximate Interval Between Onset and Death 2 weeks
Medical Certification: To Be Completed by Physician/Medical Examiner		23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 9 Unknown				23d. Date of delivery Month Day Year				
		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Respiratory Failure								23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown
		23f. Was an autopsy performed? 1 Yes 2 No				24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No				
		25. Was case referred to medical examiner? 1 Yes 2 No		26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)						
		27. Manner of Death 1 Natural 5 Pending investigation 2 Accident 6 Could not be determined 3 Suicide 4 Homicide		28a. Date of Injury (Month, Day Year) M		28b. Time of Injury M	28c. Injury at Work? 1 Yes 2 No	28d. Describe how injury occurred		
		28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 				28f. Location (Street and Number or Rural Route Number, City or Town, State) 				
		29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier Wen Xiong MD PhD				
		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Wen Xiong MD PhD Sinai Hospital of Baltimore				29c. License number 19478		29d. Date signed (Month, Day, Year) April 12, 2007		
State Registrar		31. Date filed (Month, Day, Year) APR 16 2007		32. Registrar's Signature Leanne L. Apelle		ORIGINAL				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 12006

1- For
State
Registrar

Physician
/Medical
Examiner

Funeral
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year			3. Time of Death	
Angela R. Ravita		April 13, 2007			4:15 A M	
4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of Death			4c. County of Death	
St. Martin's Home		Catonsville			Baltimore	
5. Social Security Number		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 97 Yrs.	If Under 1 Year Months Days Hours Min.	8. Date of Birth (Month, Day, Year) Sep. 17, 1909	9. Birthplace (State or Foreign Country) Maryland
Usual Residence of Decedent		10a. State Maryland			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
		10b. County Baltimore				
10e. Street and Number 601 Maiden Choice Lane		10f. Zip Code 21228			10g. Citizen of What Country? USA	
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Nun			16b. Kind of Business/Industry Religious Community	
17. Father's Name (First, Middle, Last) Domenic Ravita		18. Mother's Name (First, Middle, Maiden Surname) Antoinette Ponticello				
19a. Informant's Name/Relationship (Type, Print) Rose F. Ravita / Sister		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8100 Timberbrooke Road, Baltimore, Maryland 21237				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) New Cathedral Ceme.			Date 4/20/2007	
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229			20c. Location - City or Town, State Baltimore, Maryland	
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 			Approximate Interval Between Onset and Death	
23c. If female: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year				
23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		23f. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred	
		28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29c. License number D 21649			29d. Date signed (Month, Day, Year) April 13, 2007	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SAM BANDAN BARKER 3455 WILKENS AVE, BALTIMORE, MD 21229						
31. Date filed (Month, Day, Year) APR 16 2007		32. Registrar's Signature 				

ORIGINAL

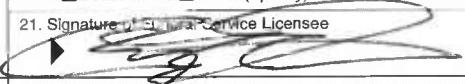
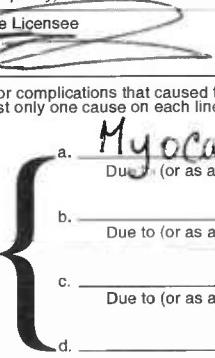
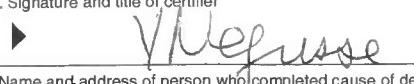
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 12007

1- For State Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) George Bernard Stahl							2. Date of Death Month 04 Day 13 Year 07	3. Time of Death 6:33 AM		
	4a. Facility Name (If not institution, give street and number) Franklin Square Hospital Center				4b. City, Town, or Location of Death Rosedale			4c. County of Death Baltimore			
Funeral Director	5. Social Security Number 155-18-8410	6. Sex M	7. Age (In yrs. last birthday) 84 Yrs.	If Under 1 Year Months 1942-	If Under 24 Hrs. Days 1946	8. Date of Birth (Month, Day, Year) 08/13/1922	9. Birthplace (State or Foreign Country) New Jersey				
To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State Maryland 10b. County Baltimore				10c. City, Town or Location Essex			10d. Inside City Limits 1 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
	10e. Street and Number 2515 Bauernschmidt Drive				10f. Zip Code 21221			10g. Citizen of What Country? U.S.A.			
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: 1942-1946		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: White			14. Race - American Indian, Black, White, etc. Specify: White			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 2		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Manager		16b. Kind of Business/Industry Car Dealer						
	17. Father's Name (First, Middle, Last) George Stahl				18. Mother's Name (First, Middle, Maiden Surname) Matilda Jurisch						
	19a. Informant's Name/Relationship (Type, Print) Concelia A. Stahl (Wife)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2515 Bauernschmidt Drive, Baltimore, Maryland 21221						
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) 				20b. Place of Disposition (Name of cemetery, crematory or other place) Bayview Crematory, Inc.		Date 04/14/2007	20c. Location - City or Town, State Baltimore, Maryland			
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Bruzdzinski Funeral Home, P.A. 1407 Old Eastern Avenue, Essex, Maryland 21221						
Physician /Medical Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Myocardial infarction									Approximate Interval Between Onset and Death	
	23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown										
	23c. If yes, outcome pf pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown									23d. Date of delivery Month Day Year	
Medical Certification: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									23e. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
										24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death Check off one Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Injury at Work? 4 <input type="checkbox"/> Homicide 8 <input type="checkbox"/> Yes 9 <input type="checkbox"/> No				28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred		
					28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
	29a. Certifier 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29c. License number RES 00000					29d. Date signed (Month, Day, Year) 04-13-07	
	29b. Signature and title of certifier 										
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Yodit Negusse 9000 Franklin Square Drive Baltimore, Md 21237										
	31. Date filed (Month, Day, Year) APR 16 2007				32. Registrar's Signature 						

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or items 23a or 28a show any injury or other traumatic event, the Medical Examiner must be notified at once.

5/2

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 200712003

1- For State Registrar

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)

Theodore Nicholas Stundick

2. Date of Death

Month April

Day 12

Year 2007

3. Time of Death

2:00 P.M.

Funeral Director

4a. Facility Name (If not institution, give street and number)

5 Brett Court Apt. 230

4b. City, Town, or Location of Death

Essex

4c. County of Death

Baltimore

5. Social Security Number

217-38-6885

6. Sex

1 M2 F

7. Age (In yrs. last birthday)

Yrs.

66

If Under 1 Year

Months

Days

Hours

Min.

8. Date of Birth

(Month, Day, Year)

04-17-1941

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent
 10a. State Maryland
 10b. County Baltimore
 10c. City, Town or Location Essex
 10d. Inside City Limits 1 Yes 2 No

10e. Street and Number 5 Brett Court Apt. 230
 10f. Zip Code 21221
 10g. Citizen of What Country? U.S.A.

To Be Completed by Funeral Director

11. Marital Status

1 Never Married 2 Married
3 Widowed 4 Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 Yes 2 No
Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12) 12

College (1-4 or 5+) 14 or 5+

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Bartender

16b. Kind of Business/Industry

Casey's Bar

17. Father's Name (First, Middle, Last)

Casimir

Stundick

18. Mother's Name (First, Middle, Maiden Surname)

Cecilia

Sawicki

19a. Informant's Name/Relationship (Type, Print)

Danielle Rosier - daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7709 Meath Road Dunkalk, Maryland 21222

20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Greenmount Crem.

Date

04-14-2007 Balto. MD

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Charles Zannino

22. Name and Address of Facility

Joseph N. Zannino Jr. Funeral Home
263 S. Conkling Street Balto. MD. 21224

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Approximate Interval Between Onset and Death

a. Due to (or as a consequence of):

Myocardial infarction

yr

b. Due to (or as a consequence of):

ASCD

yr

c. Due to (or as a consequence of):

PVD

yy

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No
9 Unknown

23c. If yes, outcome pf pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown3 Ectopic pregnancy5 Other (Specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 Yes 2 No 3 Probably 4 Unknown

25. Was case referred to medical examiner?

1 Yes 2 No

26. Place of Death Check one

Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)

27. Manner of Death

1 Natural
2 Accident
3 Suicide
4 Homicide5 Pending investigation
6 Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 Yes 2 No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR. SIMON SCALIA 2801 Hudson Street Balto MD

31. Date filed (Month, Day, Year)

APR 16 2007

32. Registrar's Signature

LAWRENCE J. SPALDING

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit once.

State Registrar

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

Within 24 hours after death.

To the

Funeral Director:

After this certificate has been signed by the attending physician, or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 12009

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Elizabeth Bertha Stokes				2. Date of Death Month Day Year April 12, 2007	3. Time of Death 8:25 P M			
	4a. Facility Name (If not institution, give street and number) St. Martin's Home		4b. City, Town, or Location of Death Catonsville		4c. County of Death Baltimore				
Funeral Director	5. Social Security Number 220-07-9487	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 97 Yrs.	If Under 1 Year Months If Under 24 Hrs. Days 8. Date of Birth (Month, Day, Year) Apr. 30, 1909	9. Birthplace (State or Foreign Country) Maryland				
	Usual Residence of Decedent Maryland Baltimore		10c. City, Town or Location Catonsville		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
To Be Completed by Funeral Director	10e. Street and Number 2 Macintosh Court #G			10f. Zip Code 21228	10g. Citizen of What Country? USA				
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Seamstress	14. Race - American Indian, Black, White, etc. Specify: White				
	17. Father's Name (First, Middle, Last) Robert Schroeder			18. Mother's Name (First, Middle, Maiden Surname) Bertha Dante					
	19a. Informant's Name/Relationship (Type. Print) Betty J. Pleasant / Daughter			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7815-J Oxford Drive, Elkridge, Maryland 21075					
	20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input checked="" type="checkbox"/> Other (Specify) Entombment		20b. Place of Disposition (Name of cemetery, crematory or other place) Loudon Park		Date 4/17/2007	20c. Location - City or Town, State Baltimore, Maryland			
	21. Signature of Funeral Service Licensee Richard Johnson								
	22. Name and Address of Facility Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229								
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Urinary tract infection Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Diabetes Mellitus						Approximate Interval Between Onset and Death		
	<p>a. Due to (or as a consequence of): Urinary tract infection</p> <p>b. Due to (or as a consequence of): Diabetes Mellitus</p> <p>c. Due to (or as a consequence of):</p> <p>d. Due to (or as a consequence of):</p>								
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown			23c. If yes, outcome pf pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____			23d. Date of delivery Month Day Year		
Medical Certification: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Dementia Hypertension						23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred			
	28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State)		
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.						29b. Signature and title of certifier SARAH RARKAW	29c. License number J21649	29d. Date signed (Month, Day, Year) April 13, 2007
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SARAH RARKAW, 3455 WILKENS AVE, BALTIMORE MD 21229			31. Date filed (Month, Day, Year) APR 16 2007		32. Registrar's Signature SARAH RARKAW			

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
 To the Funeral Director: After this certificate has been signed by the attending physician, page 2 should be detached for use as the burial-transit completely filled in by the funeral director, page 2 should be detached for use as the burial-transit once.

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 12010

1- For State Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) James W. Simmons, Sr.					2. Date of Death Month Day Year April 11, 2007	3. Time of Death 11:35P M	
Funeral Director	4a. Facility Name (If not institution, give street and number) Southern Maryland Hospital			4b. City, Town, or Location of Death Clinton		4c. County of Death P.G.		
To Be Completed by Funeral Director	5. Social Security Number 578-58-0262	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 61 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) 11-27-45	9. Birthplace (State or Foreign Country) Phila., Pa.	
To Be Completed by Funeral Director	10a. State MD.			10b. County P.G.		10c. City, Town or Location Clinton		
To Be Completed by Physician/Medical Examiner	10e. Street and Number 4503 Stecoah Drive			10f. Zip Code 20735		10g. Citizen of What Country? U.S.A.		
To Be Completed by Physician/Medical Examiner	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: Black			
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Bus Operator			16b. Kind of Business/Industry WMATA	
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) John Mack Simmons				18. Mother's Name (First, Middle, Maiden Surname) Ella Kinard			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Clarissa Simmons/Wife			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4503 Stecoah Drive, Clinton, Md. 20735				
To Be Completed by Physician/Medical Examiner	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Resurrection Cem.			Date 4/20/07	
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee Hallett W. Hackett Jr.			22. Name and Address of Facility Hackett's Funeral Chapel, Inc. 814 Upshur Street, N.W.				
To Be Completed by Physician/Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequently list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							Approximate Interval Between Onset and Death 1 mo Cancer
To Be Completed by Physician/Medical Examiner	<p>a. Due to (or as a consequence of): Chronic obstructive pulmonary Disease</p> <p>b. Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. Due to (or as a consequence of):</p>							
To Be Completed by Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown			23c. If yes, outcome pf pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____			23d. Date of delivery Month Day Year	
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Noninsulin Dependent Diabetes Mellitus							23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
To Be Completed by Physician/Medical Examiner	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred	
To Be Completed by Physician/Medical Examiner	28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.			29b. Signature and title of certifier Douglas Jordon				
To Be Completed by Physician/Medical Examiner	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9801 Geerling Ave 3-41 Silver Spring MD 20902			29c. License number 50454			29d. Date signed (Month, Day, Year) APR 12, 2007	
State Registrar	31. Date filed (Month, Day, Year) APR 16 2007		32. Registrar's Signature Jane B. Jordan					

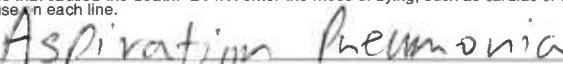
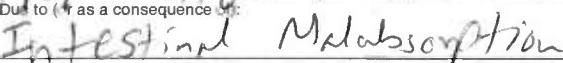
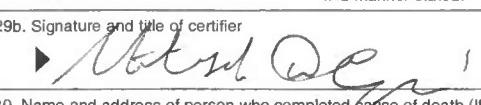
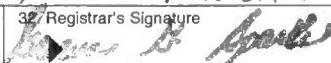
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 12011

1 - For State Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) ESTHER STEWART				2. Date of Death Month April Day 1 Year 2007		3. Time of Death 4:30 P M	
	4a. Facility Name (If not institution, give street and number) JOHNS HOPKINS BAYVIEW MEDICAL CENTER		4b. City, Town, or Location of Death BALTIMORE		4c. County of Death Maryland			
Funeral Director	5. Social Security Number 216-36-6023	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 67 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) Sept 9, 1939	9. Birthplace (State or Foreign Country) Maryland	
	10a. State Md.		10b. County Baltimore		10c. City, Town or Location Baltimore			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
To Be Completed by Funeral Director	10e. Street and Number 3404 Mueller Street			10f. Zip Code 21224		10g. Citizen of What Country? U.S.A.		
11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: White		14. Race - American Indian, Black, White, etc. White			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10th		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Factory Worker		16b. Kind of Business/Industry Blind Company				
17. Father's Name (First, Middle, Last) Edwin Stewart			18. Mother's Name (First, Middle, Maiden Surname) Genevieve Langdon					
19a. Informant's Name/Relationship (Type, Print) Estelle A. Frank / P.O.A.			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3404 Mueller Street Baltimore, Md. 21224					
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Bayview Crematory		Date 4-14-2007	20c. Location - City or Town, State Baltimore, Maryland		
21. Signature of Funeral Service Licensee 			22. Name and Address of Facility Kaczorowski Funeral Home, P.A. 1201 Dundalk Ave. Baltimore, Md. 21222					
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							Approximate Interval Between Onset and Death
	a.  b.  c. d. 							
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown			23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify)		23d. Date of delivery Month Day Year			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide			28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred		
						28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician 2 <input type="checkbox"/> Medical Examiner			29c. License number RES-000					
29b. Signature and title of certifier 			29d. Date signed (Month, Day, Year) 4/13/07					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MITESH DESAI, MD 4940 EASTERN AVE BALTIMORE MD 21224								
31. Date filed (Month, Day, Year) APR 16 2007			32. Registrar's Signature 					

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division or Vital Records, P.O. Box 68760, 

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Beg. No.

2007 | 2012

Physician /Medical Examiner		1. Decedent's Name (First, Middle, Last) Joan Bertilla Servary						2. Date of Death Month Dey Year <u>April 17 2007</u>	3. Time of Death 10:15 AM	
Funeral Director		4e Facility Name (If not institution, give street and number) Genesis Eldercare- Cromwell Center			4b. City, Town, or Location of Death Parkville		4c. County of Death Baltimore			
		5. Social Security Number <u>184-22-8346</u>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <u>77</u> Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) <u>5-17-29</u>	9. Birthplace (State or Foreign Country) Maryland		
		Usual Residence of Decedent 10a. State MD		10b. County N/A		10c. City, Town or Location Baltimore			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
		10e. Street and Number 5309 Elsrode Ave.			10f. Zip Code 21214			10g. Citizen of What Country? USA		
		11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: <u>2000</u>		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: <u>White</u>		14. Race - American Indian, Black, White, etc. Specify: White		
		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <u>12</u>			16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Secretary			16b. Kind of Business/Industry Banking		
		17. Father's Name (First, Middle, Last) Henry Witthauer			18. Mother's Name (First, Middle, Maiden Surname) Mary Adams					
		19a. Informant's Name/Relationship (Type, Print) Mr. Bruce L. Servary / Husband			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5309 Elsrode Ave. Baltimore, MD 21214					
		20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <u>Parkwood Cemetery</u>			20b. Place of Disposition (Name of cemetery, crematory or other place) Parkwood Cemetery			Date <u>4/14/2007</u>	20c. Location - City or Town, State Baltimore, MD	
		21. Signature of Funeral Service Licensee ► <u>Kimberly Davidson</u>			22. Name and Address of Facility Leonard J. Ruck, Inc. Baltimore, MD 21214			5305 Harford Rd.		
Physician /Medical Examiner		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)			e. _____ Due to (or as a consequence of): <u>Congestive Heart failure</u>			Approximate Interval Between Onset and Death		
		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last			b. _____ Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____					
		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Dementia</u>			23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown					
		25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) <u>4A</u>					
		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide			28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred		
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State)		
		29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
		29b. Signature and title of certifier ► <u>Karen L. Attending Physician</u>			29c. License number <u>053682</u>			29d. Date signed (Month, Day, Year) <u>Apr. 12 2007</u>		
		30. Name and address of person who completed cause of death (Item 28e). (Type, Print) <u>X/AD 1700 6701 N. Charles ST. 4202 Baltimore 21204</u>								
State Registrar		31. Date filed (Month, Day, Year) <u>APR 16 2007</u>		32. Registrar's Signature <u>Debra A. Miller</u>						

Division of Vital Records, P.O. Box 68760,

To The Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "nature", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2007 12013

1- For State
Registrar

Reg. No.

Physician/
Medical ExaminerFuneral
Director

To Be Completed by Funeral Director

Baltimore, MD 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filed in by the funeral director, page 2 should be detached for use as the burial - transit

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) Mattie Beatrice Stokes			2. Date of Death Month Day Year March 16, 2007	3. Time of Death 0127 hrs
4a. Facility Name (if not institution, give street and number) Mercy Hospital			4b. City, Town, or Location of Death Baltimore City	
5. Social Security Number 212-76-1238			6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 49 Yrs.
			If Under 1 Year Months Days	If Under 24 Hrs. Hours Min
			8. Date of Birth (MM/DD/YYYY) 12/14/1957	
			9. Birthplace (State or Foreign Country) MD	
Usual Residence of Decedent				
10a. State MD	10b. County	10c. City, Town or Location Baltimore		
10e. Street and Number 3120 Federal Street			10f. Zip Code 21213	10g. Citizen of What Country? U.S.A.
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No specify:		14. Race - American Indian, Black, White, etc. Black Specify:
13. Widowed <input type="checkbox"/>	14. Divorced <input type="checkbox"/>			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Domestic Worker		16b. Kind of Business/Industry Private
College (1-4 or 5+)				
17. Father's Name (First, Middle, Last) Sylvester Stokes			18. Mother's Name (First, Middle, Maiden Surname) Cora Lee Huggins	
19a. Informant's Name/Relationship (Type, Print) Ernestine Holmes/stepfather			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3120 Federal St. Baltimore, MD 21213	
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State		20b. Place of Disposition (Name of cemetery, crematory or other place) Mt. Zion Cemetery		Date 03/23/07
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other Specify: <i>Be Taylor</i>				20c. Location - City or Town, State Baltimore, MD
21. Signature of Funeral Service Licensee <i>Be Taylor</i>				
22. Name and Address of Facility Taylor's Funeral Home 1722 N. Capitol St. NW Washington, DC 20002				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.				
a. <u>Intracerebral hemorrhage</u> Due to (or as a consequence of):				
b. _____ Due to (or as a consequence of):				
c. _____ Due to (or as a consequence of):				
d. _____				
<input checked="" type="checkbox"/> UNPENDED		<input type="checkbox"/> AMENDED #23a, PII, 27, per ME, g866, 4/18/07 TT		
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				
23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown				
Cocaine use		24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		
		24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		26 Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other:		
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated		29c. License number O.C.M.E.		
		29d. Date signed (Month, Day, Year) March 16, 2007		
30. Name and address of person who completed cause of death (Item 23a) Susan Hogan MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201				
31. Date filed (Month, Day, Year) APR 16 2007		32. Registrar's Signature <i>Laura B. Taylor</i>		

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 12014

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>Tadeo Sagastume</i>				2. Date of Death Month April Day 13 Year 2007	3. Time of Death 7:13 P.M.		
	4a. Facility Name (If not institution, give street and number) Northwest Hospital Center		4b. City, Town, or Location of Death Randallstown		4c. County of Death Baltimore			
Funeral Director	5. Social Security Number 219-51-9376		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 78 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Hours	8. Date of Birth (Month, Day, Year) May 6, 1928	9. Birthplace (State or Foreign Country) Guatemala
	Usual Residence of Decedent Maryland Baltimore		10c. City, Town or Location Owings Mills				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
To Be Completed by Funeral Director	10a. State Maryland		10b. County Baltimore		10f. Zip Code 21117		10g. Citizen of What Country? United States of America	
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: <i>XX</i> Yes <input type="checkbox"/> No Specify: <i>Guatemalan</i>		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Specify: <i>White</i>		14. Race - American Indian, Black, White, etc. Specify: <i>White</i>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 6th		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Landscaper		16b. Kind of Business/Industry Construction			
	17. Father's Name (First, Middle, Last) Abrahan Sagastume		18. Mother's Name (First, Middle, Maiden Surname) Pastora Sagastume					
	19a. Informant's Name/Relationship (Type, Print) Edgar S. Sagastume (Son)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15 Candor Court; Reisterstown, Maryland 21136					
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input checked="" type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <i>Ipala Cemetery</i>		20b. Place of Disposition (Name of cemetery, crematory or other place) Ipala Cemetery		Date April 21, 2007	20c. Location - City or Town, State Chiquimula, Guatemala		
	21. Signature of Funeral Service Licensee <i>John J. Smith</i>		22. Name and Address of Facility Eckhardt Funeral Chapel, P.A. 21117 11605 Reisterstown Road; Owings Mills, Maryland					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		23b. Due to (or as a consequence of): <i>Amyotrophic lateral sclerosis</i>		Approximate Interval Between Onset and Death			
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		b. Due to (or as a consequence of):					
			c. Due to (or as a consequence of):					
			d. Due to (or as a consequence of):					
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown <input type="checkbox"/> Other (specify) _____		23d. Date of delivery Month Day Year			
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown			
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 28d. Describe how injury occurred	
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) <i>At home</i>		28f. Location (Street and Number or Rural Route Number, City or Town, State) <i>Randallstown</i>			
	29b. Signature and title of certifier <i>Trung Pham MD</i>		29c. License number D47704		29d. Date signed (Month, Day, Year) 4/13/2007			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Trung Pham MD Northwest Hospital Center							
	31. Date filed (Month, Day, Year) APR 16 2007		32. Registrar's Signature <i>Leanne B. Jones</i>					

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760, *X*
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State
Registrar

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#10b per FH G866, 4/16/07, WS&IT9b
State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2007 12015

Physician /Medical Examiner		1. Decedent's Name (First, Middle, Last) EMMA STAGGERS					2. Date of Death Month Day Year APRIL 10, 2007		3. Time of Death 1820 PM		
Funeral Director		4a. Facility Name (If not institution, give street and number) NORTHWEST HOSPITAL			4b. City, Town, or Location of Death RANDALLSTOWN			4c. County of Death BALTIMORE			
To Be Completed by Funeral Director		5. Social Security Number 242-42-2663	6. Sex 1 M 2 F	7. Age (In yrs. last birthday) 74 Yrs.	If Under 1 Year Months 2	If Under 24 Hrs. Days 0	Hours 0	Min. 0	8. Date of Birth (Month, Day, Year) 2-23-1933	9. Birthplace (State or Foreign Country) Virginia	
To Be Completed by Physician/Medical Examiner		10a. State MD			10b. County Gwynn	10c. City, Town or Location Gwynn Oak			10d. Inside City Limits 1 Yes 2 No		
To Be Completed by Physician/Medical Examiner		10e. Street and Number 6 Crismers Court			10f. Zip Code 21207			10g. Citizen of What Country? USA			
To Be Completed by Physician/Medical Examiner		11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: 4 yrs			13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No Specify: Black			
To Be Completed by Physician/Medical Examiner		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Nurse			16b. Kind of Business/Industry Health Care			
To Be Completed by Physician/Medical Examiner		17. Father's Name (First, Middle, Last) Paul E. Wright			18. Mother's Name (First, Middle, Maiden Surname) Bessie Robinson						
To Be Completed by Physician/Medical Examiner		19a. Informant's Name/Relationship (Type, Print) Erman R. Staggers Husband			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Garrison forest 4-18-07 Owings Mills, MD						
To Be Completed by Physician/Medical Examiner		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Garrison forest			Date 4-18-07	20c. Location - City or Town, State Owings Mills, MD		
To Be Completed by Physician/Medical Examiner		21. Signature of Funeral Service Licensee Vaughn C. Greene			22. Name and Address of Facility 8728 Liberty Rd, Randallstown, MD 21133						
To Be Completed by Physician/Medical Examiner		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) respiratory failure						Approximate Interval Between Onset and Death			
To Be Completed by Physician/Medical Examiner		23b. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last pulmonary fibrosis									
To Be Completed by Physician/Medical Examiner		23c. If female: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown			23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify)			23d. Date of delivery Month Day Year			
To Be Completed by Physician/Medical Examiner		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown			
To Be Completed by Physician/Medical Examiner		25. Was case referred to medical examiner? 1 Yes 2 No			26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)						
To Be Completed by Physician/Medical Examiner		27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide			28a. Date of Injury (Month, Day Year) 5 Pending investigation	28b. Time of Injury M	28c. Injury at Work? 1 Yes 2 No	28d. Describe how injury occurred			
To Be Completed by Physician/Medical Examiner		28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be determined						28f. Location (Street and Number or Rural Route Number, City or Town, State)			
To Be Completed by Physician/Medical Examiner		29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
To Be Completed by Physician/Medical Examiner		29b. Signature and title of certifier D. Fitzpatrick MD			29c. License number DO059736			29d. Date signed (Month, Day, Year) April 10, 2007			
To Be Completed by Physician/Medical Examiner		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DEBORAH WATSON FITZPATRICK MD									
To Be Completed by Physician/Medical Examiner		31. Date filed (Month, Day, Year) APR 16 2007			32. Registrar's Signature [Signature]						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

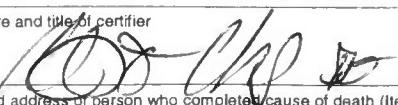
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2007 12016

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) KATHERINE deDORY SMITH							2. Date of Death Month APR 6 Day 2007 Year	3. Time of Death 7:50 P M
	4a. Facility Name (If not institution, give street and number) NATIONAL NAVAL MEDICAL CENTER			4b. City, Town, or Location of Death BETHESDA			4c. County of Death MONTGOMERY		
Funeral Director	5. Social Security Number 074-32-8871	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 94 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days Hours Min.	8. Date of Birth (Month, Day, Year) JANUARY 6, 1913	9. Birthplace (State or Foreign Country) HUNGARY		
	Usual Residence of Decedent 10a. State MARYLAND			10b. County MONTGOMERY			10c. City, Town or Location ROCKVILLE		
To Be Completed by Funeral Director	10e. Street and Number 5802 NICHOLSON LANE UNIT 2-LO-6				10f. Zip Code 20852-2965		10g. Citizen of What Country? UNITED STATES		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: WHITE		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) LIBRARIAN			16b. Kind of Business/Industry LIBRARY		
17. Father's Name (First, Middle, Last) MORRIS ZAPNER					18. Mother's Name (First, Middle, Maiden Surname) RENE LANGRAT				
19a. Informant's Name/Relationship (Type, Print) KATHERINE BENYOZKY/ DAUGHTER					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 55 BUTTON WOOD LANE, DOYLESTOWN, PENNSYLVANIA 18901				
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) MONTGOMERY CREMATORIUM INC.			Date APRIL 11, 2007	20c. Location - City or Town, State BETHESDA, MARYLAND		
21. Signature of Funeral Service Licensee 					22. Name and Address of Facility ROBERT A. PUMPHREY FUNERAL HOME/ BETHESDA-CHEVY CHASE, INC. 7557 WISCONSIN AVENUE BETHESDA, MARYLAND 20814-3501				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) PNEUMONIA								Approximate Interval Between Onset and Death	
b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):									
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Unknown						23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
								24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)	
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide <input type="checkbox"/> Determined 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)								28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								29d. Date signed (Month, Day, Year) 04/09/07	
29b. Signature and title of certifier 								29c. License number RES-000	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ROBERT T. DENDALL LT MC USN								NATIONAL NAVAL MEDICAL CENTER BETHESDA MD 20889-5600	
31. Date filed (Month, Day, Year) APR 16 2007		32. Registrar's Signature 							

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transit once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

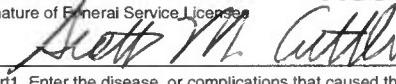
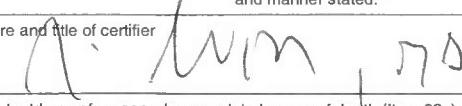
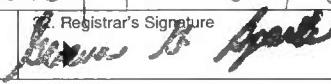
State
Registrar

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State of Maryland / Department of Health and Mental Hygiene

1- For State Register Amend #1 Per Phy G866 4/16/07 Certificate of Death

#10f&20b Reg. No. 2007 12017

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last)				2. Date of Death				3. Time of Death		
	RUTH SACKS SACKS				Month April Day 12 Year 2007				4:50A M		
Funeral Director	4a. Facility Name (If not institution, give street and number)				4b. City, Town, or Location of Death				4c. County of Death		
	2521 SMITH AVENUE				BALTIMORE				BALTIMORE		
	5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	9. Birthplace (State or Foreign Country)				
	215-03-2511	1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	95 Yrs.	Months	Days	Hours	Min.	12/28/1911	MD		
	Usual Residence of Decedent				10c. City, Town or Location				10d. Inside City Limits		
	10a. State	10b. County	BALTIMORE						1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
	MD	BALTIMORE	BALTIMORE								
	10e. Street and Number				10f. Zip Code				10g. Citizen of What Country?		
	2521 SMITH AVENUE				21209				U.S.A.		
	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?			13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)			14. Race - American Indian, Black, White, etc.			
	1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:			1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			WHITE Specify:			
	15. Decedent's Education (Specify only highest grade completed)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)				16b. Kind of Business/Industry		
	Elementary/Secondary (0-12)		College (1-4 or 5+)		HOMEMAKER				OWN HOME		
	2										
	17. Father's Name (First, Middle, Last)				18. Mother's Name (First, Middle, Maiden Surname)						
	HENRY				WEINER JENNIE				GREENBLATT		
	19a. Informant's Name/Relationship (Type, Print)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)						
	FRED SACKS / SON				2 LATIMORE COURT - REISTERSTOWN, MD. 21136						
	20a. Method of Disposition				20b. Place of Disposition (Name of cemetery, crematory or other place)				Date 2007	20c. Location - City or Town, State	
	1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) BNAY ISRAEL CONG.								04/13/2004	BALTIMORE, MD	
	21. Signature of Funeral Service Licensee				22. Name and Address of Facility				SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208		
											
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.										
	Immediate Cause (Final disease or condition resulting in death) <i>Congestive heart failure</i>										
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <i>Atrial fibrillation</i>										
	a. Due to (or as a consequence of):										
	b. Due to (or as a consequence of):										
	c. Due to (or as a consequence of):										
	d. Due to (or as a consequence of):										
	Approximate Interval Between Onset and Death										
	IF FEMALE:				23c. If yes, outcome pf pregnancy				23d. Date of delivery		
	23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown				1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 4 <input type="checkbox"/> Pregnant at time of death 9 <input type="checkbox"/> Unknown				Month Day Year		
	23e. Did tobacco use contribute to the cause of death?										
					1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown						
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Rheumatoid arthritis</i>				23e. Did tobacco use contribute to the cause of death?						
					1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown						
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No						
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one)						
	Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA				Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day Year)				28b. Time of Injury M		
	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No				28d. Describe how injury occurred						
	28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)						
	29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29c. License number				29d. Date signed (Month, Day, Year)		
					A 30339				04/12/07		
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Alison WINTER, 4000 Old Court Rd, Baltimore, MD 21208</i>										
	31. Date filed (Month, Day, Year)				32. Registrar's Signature						
	APR 16 2007										

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

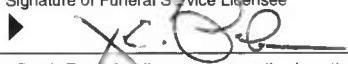
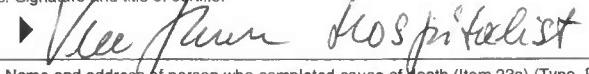
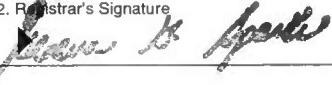
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2007 12018

1- For
State
Registrar

Physician /Medical Examiner		1. Decedent's Name (First, Middle, Last) Michael S. Terpilak						2. Date of Death Month Day Year April 11, 2007		3. Time of Death 13:08 M		
Funeral Director		4a. Facility Name (If not institution, give street and number) Montgomery General Hospital			4b. City, Town, or Location of Death Olney			4c. County of Death Montgomery				
To Be Completed by Funeral Director		5. Social Security Number 053-24-2490		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) 78 Yrs.	If Under 1 Year Months Days Hours Min. 0 0 0 0	8. Date of Birth (Month, Day, Year) Nov. 19, 1928	9. Birthplace (State or Foreign Country) New York				
		Usual Residence of Decedent 10a. State Maryland		10b. County Montgomery		10c. City, Town or Location Silver Spring			10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
		10e. Street and Number 1916 Grayslake Drive			10f. Zip Code 20906			10g. Citizen of What Country? United States				
		11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: Korean Conflict		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: White			14. Race - American Indian, Black, White, etc.			
		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 5			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Health Physicist			16b. Kind of Business/Industry U.S. Public Health Services				
		17. Father's Name (First, Middle, Last) Dymetro Terpilak				18. Mother's Name (First, Middle, Maiden Surname) Josephine Sciora						
		19a. Informant's Name/Relationship (Type, Print) Katherine A. Terpilak / Wife			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1916 Grayslake Drive, Silver Spring, MD 20906							
		20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Gate of Heaven Cemetery			Date April 16, 2007	20c. Location - City or Town, State Silver Spring, Maryland				
		21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. 7557 Wisconsin Ave., Bethesda, MD 20814-3501								
		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last						Approximate Interval Between Onset and Death				
		<p>a. <i>Cerebrovascular accident</i> Due to (or as a consequence of):</p> <p>b. <i>Hypertension</i> Due to (or as a consequence of):</p> <p>c. <i>Congestive heart failure</i> Due to (or as a consequence of):</p> <p>d.</p>										
		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome pf pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) _____			23d. Date of delivery Month Day Year					
		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown				
		25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			23f. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred				
		29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		28e. Place of injury : At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)					
		29b. Signature and title of certifier 		29c. License number D 005 9414			29d. Date signed (Month, Day, Year) April 12, 2007					
		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. RACHEL RACZEK										
		31. Date filed (Month, Day, Year) APR 16 2007		32. Registrar's Signature 								

Baltimore, Maryland 21215-0036

Department of Health and Mental Hygiene
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 12019

1- For
State
RegistrarPhysician
/Medical
ExaminerFuneral
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. "Important: If item 27 is marked other than 'natural'; or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once."

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

1. Decedent's Name (First, Middle, Last) Kelvin Vincent				2. Date of Death Month April Day 10 Year 2007	3. Time of Death M												
4a. Facility Name (If not institution, give street and number) northwest Hospital				4b. City, Town, or Location of Death Randallstown													
5. Social Security Number 215-78-9312		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 45 Yrs.	If Under 1 Year Months 09 Days 28	If Under 24 Hrs. Hours 10 Min. 00												
				8. Date of Birth (Month, Day, Year) 09 28 1961													
				9. Birthplace (State or Foreign Country) Md													
10a. State MD		10b. County Baltimore		10c. City, Town or Location Mandalystown													
10e. Street and Number 8 Plum Tree Court				10f. Zip Code 21133	10g. Citizen of What Country? USA												
11. Marital Status 1 <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: 2000		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: Black													
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 2 Years		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Field manager		16b. Kind of Business/Industry Protection													
17. Father's Name (First, Middle, Last) James Vincent		18. Mother's Name (First, Middle, Maiden Surname) Sarah Weaver															
19a. Informant's Name/Relationship (Type, Print) Ida Vincent / Wife		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8 Plum Tree Court Randallstown MD 21133															
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) Arbutus		20b. Place of Disposition (Name of cemetery, crematory or other place) Arbutus		Date 04.16.07	20c. Location - City or Town, State Baltimore MD												
21. Signature of Funeral Service Licensee Vaym C. Greene		22. Name and Address of Facility Vaym C. Greene & Son Inc 8728 Liberty Road Randallstown MD 21133															
23a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <table border="1"> <tr> <td>Immediate Cause (Final disease or condition resulting in death)</td> <td>a. Due to (or as a consequence of): Phenyluria</td> <td>Approximate Interval Between Onset and Death</td> </tr> <tr> <td>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</td> <td>b. Due to (or as a consequence of): Acquired immunodeficiency syndrome</td> <td></td> </tr> <tr> <td></td> <td>c. Due to (or as a consequence of):</td> <td></td> </tr> <tr> <td></td> <td>d. Due to (or as a consequence of):</td> <td></td> </tr> </table>						Immediate Cause (Final disease or condition resulting in death)	a. Due to (or as a consequence of): Phenyluria	Approximate Interval Between Onset and Death	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of): Acquired immunodeficiency syndrome			c. Due to (or as a consequence of):			d. Due to (or as a consequence of):	
Immediate Cause (Final disease or condition resulting in death)	a. Due to (or as a consequence of): Phenyluria	Approximate Interval Between Onset and Death															
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of): Acquired immunodeficiency syndrome																
	c. Due to (or as a consequence of):																
	d. Due to (or as a consequence of):																
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome pf pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year													
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.																	
23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown																	
23f. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No															
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death Check only one Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)															
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work? M 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred												
		28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)													
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.																	
29b. Signature and title of certifier Alice Vincent		29c. License number H 43974		29d. Date signed (Month, Day, Year) Apr. 10, 2007													
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Alice Vincent northwest Hospital Randallstown Maryland																	
31. Date filed (Month, Day, Year) APR 16 2007		32. Registrar's Signature John B. Hall															

15

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 12020

1- For
State
RegistrarPhysician
/Medical
ExaminerFuneral
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after a death.
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit once.

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

1. Decedent's Name (First, Middle, Last) Frankie Bennie Wolf		2. Date of Death Month Day Year April 12, 2007		3. Time of Death 8:55 a.m.
4a. Facility Name (If not institution, give street and number) Gilchrist Center		4b. City, Town, or Location of Death Towson		4c. County of Death Baltimore
5. Social Security Number 243-30-5568		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 84 Yrs.	If Under 1 Year Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Dec. 18, 1922
Usual Residence of Decedent 10a. State Maryland		10b. County Baltimore		9. Birthplace (State or Foreign Country) South Carolina
10c. City, Town or Location Dundalk		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
10e. Street and Number 7101 Holabird Avenue		10f. Zip Code 21222		10g. Citizen of What Country? United States
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: +2		13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: White
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) +2		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Management		16b. Kind of Business/Industry Manufacturing
17. Father's Name (First, Middle, Last) Unknown		18. Mother's Name (First, Middle, Maiden Surname) Mary Nelson		
19a. Informant's Name/Relationship (Type, Print) Abbey Laine Yeske (Granddaughter)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 218 N. Charles St., Apt. 2209 Balto., Md. 21201		
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) Meadowridge Mem. Pk.		20b. Place of Disposition (Name of cemetery, crematory or other place) Meadowridge Mem. Pk.		Date 4/16/2007
21. Signature of Funeral Service Licensee D. C. Calo		22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Avenue Dundalk, Maryland 21222		20c. Location - City or Town, State Dorsey, Maryland
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Ovarian Cancer				Approximate Interval Between Onset and Death months
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		a. Due to (or as a consequence of): Ovarian Cancer		
		b. Due to (or as a consequence of):		
		c. Due to (or as a consequence of):		
		d. Due to (or as a consequence of):		
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown <input type="checkbox"/> Other (Specify) Hospital		23d. Date of delivery Month Day Year
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
				24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) Hospital		
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
		28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29c. License number D 58303		29d. Date signed (Month, Day, Year) April 12 2007
29b. Signature and title of certifier Aaron J. Ottaviano		29d. Date signed (Month, Day, Year) April 12 2007		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Aaron J. Ottaviano MD 6701 N. Charles St Towson MD 21204		32. Registrar's Signature Leanne B. Aponte		
31. Date filed (Month, Day, Year) APR 16 2007		32. Registrar's Signature Leanne B. Aponte		

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

amend item 5 per th 866 4-20-07 vt
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 12021

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) MARY WURTZER							2. Date of Death Month April Day 15 Year 2007	3. Time of Death 1:25 PM
	4a. Facility Name (If not institution, give street and number) St. Joseph's Nursing Home				4b. City, Town, or Location of Death Catonsville			4c. County of Death Baltimore	
Funeral Director	5. Social Security Number 216-16-5714 216-32-8287		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 98 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) Oct 31, 1908	9. Birthplace (State or Foreign Country) Maryland	
Usual Residence of Decedent									
10a. State MD		10b. County Howard		10c. City, Town or Location Ellicott City					10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
10e. Street and Number 4020 Old Columbia Pike			10f. Zip Code 21043				10g. Citizen of What Country? United States		
Physician /Medical Examiner	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: 12		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: White			14. Race - American Indian, Black, White, etc. Specify:
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)				16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Bookkeeper					16b. Kind of Business/Industry Produce Company
17. Father's Name (First, Middle, Last) Patrick Kirwan					18. Mother's Name (First, Middle, Maiden Surname) Mary Elizabeth Burns				
19a. Informant's Name/Relationship (Type, Print) Augustus S. Wurtzer, Sr./Son					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4016 Old Columbia Pike Ellicott City, MD 21043				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Woodlawn Cemetery			Date 4-21-2007	20c. Location - City or Town, State Baltimore, MD		
21. Signature of Funeral Service Licensee  ► Harry H. Witzke's Family FH Inc.									
22. Name and Address of Facility 4112 Old Columbia Pike Ellicott City, MD 21043									
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.									
Immediate Cause (Final disease or condition resulting in death) a. ARTERIOSCLER DISEASE, GENERAL Due to (or as a consequence of): DECADES									
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. _____ Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____									
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown									
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No									
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No									
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred			
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29d. Date signed (Month, Day, Year) APRIL 16 2007							
29b. Signature and title of certifier 		29c. License number D 01786							
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Laurence Gallagher MD 714 Mainen Choice Lane, Baltimore, MD 21208									
31. Date filed (Month, Day, Year) APR 16 2007		32. Registrar's Signature 							

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
 Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 12022

1- For
State
RegistrarPhysician
/Medical
ExaminerFuneral
Director

Baltimore, Maryland 21215-0036
 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
 Department of Health and Mental Hygiene.
 Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show
 any injury or other traumatic event, the Medical Examiner must be notified at
 once.

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
 within 24 hours after death.
 To the Funeral Director: After this certificate has been signed by the attending physician and
 completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last)		2. Date of Death		3. Time of Death
<i>DAVID WEATHERSBEE</i>		Month	Day	Year
4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of Death		4c. County of Death
<i>HOWARD COUNTY GEN. HOSPITAL</i>		<i>COLUMBIA</i>		<i>HOWARD</i>
5. Social Security Number	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <i>86</i>	If Under 1 Year Months	If Under 24 Hrs. Hours
		Yrs.	Min.	8. Date of Birth (Month, Day, Year) <i>NOV 14 1920</i>
9. Birthplace (State or Foreign Country) <i>WASH., D.C.</i>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
10a. State <i>MD</i>		10b. County <i>HOWARD</i>		10c. City, Town or Location <i>COLUMBIA</i>
10e. Street and Number <i>5647 C HARPERS FARM ROAD</i>		10f. Zip Code <i>21044</i>		10g. Citizen of What Country? <i>USA</i>
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> If Yes, Give Year or Dates: <i>1943-1946</i>		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: <i>WHITE</i>
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 4+		16b. Kind of Business/Industry <i>INTERSTATE commerce comm.</i>
17. Father's Name (First, Middle, Last) <i>FRANK WEATHERSSEE</i>		18. Mother's Name (First, Middle, Maiden Surname) <i>ROSE BROWN</i>		
19a. Informant's Name/Relationship (Type, Print) <i>DOROTHY WEATHERSSEE/WIFE</i>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>5647 C HARPERS FARM RD COLUMBIA MD 21044</i>		
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) <i>Jeff N. Zumbrum</i>		20b. Place of Disposition (Name of cemetery, crematory or other place) <i>South CARROLL Crem.</i>		Date <i>4/16/2007</i>
21. Signature of Funeral Service Licensee <i>Jeff N. Zumbrum</i>		20c. Location - City or Town, State <i>WINFIELD, MD</i>		
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <i>Precordial</i>		22. Name and Address of Facility <i>JN ZUMBURN FH & mow Co.</i>		
23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome pf pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown		
23d. Date of delivery Month Day Year				
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Chronic obstructive Pulmonary Disease</i>		23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined		28a. Date of injury (Month, Day Year)	28b. Time of injury M	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
		28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Describe how injury occurred
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <i>KENNETH SETTLE MD</i>		
		29c. License number <i>DS3987</i>		29d. Date signed (Month, Day, Year) <i>April 15 2007</i>
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>KENNETH SETTLE MD</i>		32. Registrar's Signature <i>Debra B. Spangler</i>		
31. Date filed (Month, Day, Year) <i>APR 16 2007</i>				

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

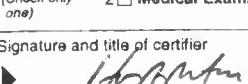
1- For
State
Registrar

Amend #26, per MD, g866, 4/16/07

Certificate of Death

Reg. No.

2007 12023

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last)						2. Date of Death Month Day Year	3. Time of Death		
	Lois Weimer						4	7 07	0145AM	
Funeral Director	4a. Facility Name (If not institution, give street and number)			4b. City, Town, or Location of Death			4c. County of Death			
	Johns Hopkins Bayview			Baltimore						
To Be Completed by Funeral Director	5. Social Security Number		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 72 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days Hours Min.	8. Date of Birth (Month, Day, Year) 2-4-1935	9. Birthplace (State or Foreign Country) MD		
	213-32-7679									
Usual Residence of Decedent										
10a. State	10b. County		10c. City, Town or Location					10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
MD	Baltimore		Dundalk							
10e. Street and Number 32 Liberty Parkway				10f. Zip Code 21222			10g. Citizen of What Country? USA			
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker			16b. Kind of Business/Industry Own Home				
17. Father's Name (First, Middle, Last) Herbert E. Amey, Sr.				18. Mother's Name (First, Middle, Maiden Surname) Lucille Clark						
19a. Informant's Name/Relationship (Type, Print) Robert Weimer - Husband				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 32 Liberty Parkway, Dundalk, MD 21222						
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Bayview Crematory			Date 4-11-07	20c. Location - City or Town, State Baltimore, MD		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Bradley-Ashton Funeral Home, PA, 2134 Willow Spring Road, 21222						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.										
Immediate Cause (Final disease or condition resulting in death) ASCVD										
Approximate Interval Between Onset and Death Long Standing										
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last										
<p>a. Due to (or as a consequence of): ASCVD</p> <p>b. Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. _____</p>										
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown				23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____ <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										
23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown										
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input checked="" type="checkbox"/> Home Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> _____ <input type="checkbox"/> Other (Specify) _____			24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide				28a. Date of Injury (Month, Day Year)		28b. Time of Injury	28c. Injury at Work? M <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)						
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier 					29c. License number D-0061115	29d. Date signed (Month, Day, Year) 4/17/07
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hardin Partle 4940 Eastern Ave. Baltimore MD 21224				32. Registrar's Signature 						
31. Date filed (Month, Day, Year) APR 16 2007		32. Registrar's Signature								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2007 12024

Certificate of Death

Reg. No.

1- For State Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) HAROLD HENRY ARNOLD						2. Date of Death Month Day Year April 7, 2007	3. Time of Death 9:30 AM			
	4a. Facility Name (If not institution, give street and number) Upper Chesapeake Medical Center			4b. City, Town, or Location of Death Bel Air			4c. County of Death Harford				
Funeral Director	5. Social Security Number 212-26-7638		6. Sex M	7. Age (In yrs. last birthday) 78 Yrs.	If Under 1 Year Months Days Hours Min.	8. Date of Birth (Month, Day, Year) 8/26/1928		9. Birthplace (State or Foreign Country) Maryland			
	Usual Residence of Decedent MD.		10a. State MD.		10b. County Harford		10c. City, Town or Location Street		10d. Inside City Limits 1 Yes 2 No		
To Be Completed by Funeral Director	10e. Street and Number 946 Coen Road				10f. Zip Code 21154		10g. Citizen of What Country? United States				
	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No Specify:			14. Race - American Indian, Black, White, etc. White			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+)		16b. Kind of Business/Industry Truck Driver			Milk Co-op			
	17. Father's Name (First, Middle, Last) Allen W. Arnold				18. Mother's Name (First, Middle, Maiden Surname) Helen Daughton						
	19a. Informant's Name/Relationship (Type, Print) Deborah Knopp (Daughter)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 430 Underwood Circle Bel Air, Md. 21014						
	20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Bel Air Mem. Gardens		Date 4/11/2007	20c. Location - City or Town, State Bel Air, Maryland					
	21. Signature of Funeral Service Person M. Gladden Kurtz		22. Name and Address of Facility Jarrettsville, Maryland E.G. Kurtz & Son Funeral Home, P.A.								
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause per each line. Immediate Cause (Final disease or condition resulting in death) Liver Neoplasms						Approximate Interval Between Onset and Death 4 days				
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Pancreatic Cancer										
	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown						23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (Specify)				
							23d. Date of delivery Month Day Year				
Division or Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Coronary Disease, Hypertension						23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown				
							23f. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No				
Medical Certification: To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 Yes 2 No						26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
	27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide		28a. Date of Injury (Month, Day Year) M		28b. Time of Injury 1 Yes 2 No	28c. Injury at Work? 1 Yes 2 No			28d. Describe how injury occurred		
	5 Pending investigation 6 Could not be determined		28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)						
	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.						29b. Signature and title of certifier Nesreen Kultarni D.O.			29c. License number H0062745	29d. Date signed (Month, Day, Year) April 8, 2007
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Nesreen Kultarni D.O. 500 Upper Chesapeake Dr. Bel Air, MD 21014						31. Date filed (Month, Day, Year) APR 16 2007			32. Registrar's Signature Leanne B. Parker	

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2007 12025
Reg. No.1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Thelma Krehbiel Adams							2. Date of Death Month March	Day 28 , 2007	Year 2:45 P.M.		
	4a. Facility Name (If not institution, give street and number) Wilson Health Care Center			4b. City, Town, or Location of Death Gaithersburg			4c. County of Death Montgomery					
Funeral Director	5. Social Security Number 083-20-1876	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 90 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) Feb. 5, 1917	9. Birthplace (State or Foreign Country) Kansas					
	Usual Residence of Decedent Maryland Montgomery Gaithersburg			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No								
To Be Completed by Funeral Director	10a. State Maryland			10b. County Montgomery			10c. City, Town or Location Gaithersburg					
	10e. Street and Number 419 Russell Avenue, # 403			10f. Zip Code 20877			10g. Citizen of What Country? United States					
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White					
	15. Decedent's Usual Occupation (Specify only highest grade completed) Elementary/Secondary (0-12)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 5+		16b. Kind of Business/Industry Teacher							
	17. Father's Name (First, Middle, Last) Jacob Krehbiel			18. Mother's Name (First, Middle, Maiden Surname) Elizabeth Weidel								
	19a. Informant's Name/Relationship (Type, Print) Curtis Frank Adams/Husband			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 419 Russell Avenue, # 403, Gaithersburg, MD. 20877								
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Metropolitan Crematory			Date 3/29/2007	20c. Location - City or Town, State Alexandria, Virginia				
	21. Signature of Funeral Service Licensee 			22. Name and Address of Facility DeVol Funeral Home			10 East Deer Park Dr., Gaithersburg, MD. 20877					
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Congestive heart failure							Approximate Interval Between Onset and Death One month				
	b. Due to (or as a consequence of): Serious mitral regurgitation											
	c. Due to (or as a consequence of):											
	d. Due to (or as a consequence of):											
Division of Vital Records, P.O. Box 68760, Medical Certification: To Be Completed by Physician/Medical Examiner	23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown							23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown		23d. Date of delivery Month March	Day 28	Year 2007
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Hypertension, Decease effusion, Atonemia, Anemia, Chronic disease, Esophagitis							23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown				
10	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred					
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)							28f. Location (Street and Number or Rural Route Number, City or Town, State)				
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							29c. License number 104115			29d. Date signed (Month, Day, Year) March 28, 2007	
	30. Name and address of person who completed cause of death (Item 2a) (Type, Print) Dr. ROBERT BIRSCHOFF M.D.							32. Registrar's Signature 				
State Registrar	31. Date filed (Month, Day, Year) APR 02 2007			32. Registrar's Signature			33. Date signed (Month, Day, Year)					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2007 12026

1- For State Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) LEWIS E BLUMENAUER				2. Date of Death Month April Day 8, Year 2007	3. Time of Death 10:35 AM	
	4a. Facility Name (If not institution, give street and number) FREDERICK MEMORIAL HOSPITAL		4b. City, Town, or Location of Death FREDERICK		4c. County of Death FREDERICK		
Funeral Director	5. Social Security Number 215-26-8442	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 76 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days Hours Min.	8. Date of Birth (Month Day, Year) May 26, 1930	9. Birthplace (State or Foreign Country) Maryland
To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State Maryland 10b. County Frederick 10c. City, Town or Location Frederick						10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
	10e. Street and Number 6 College Avenue			10f. Zip Code 21701		10g. Citizen of What Country? U.S.A.	
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: 1951-1953		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Secretary-Treasurer		16b. Kind of Business/Industry Food Produce Co.		
	17. Father's Name (First, Middle, Last) Charles S. Blumenauer			18. Mother's Name (First, Middle, Maiden Surname) Pauline C. Shearer			
	19a. Informant's Name/Relationship (Type, Print) John F. Dallavalle, PR			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7360 Guilford Dr., Suite 203, Frederick, MD 21704			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Mount Olivet Cemetery		Date Apr. 12, 2007	20c. Location - City or Town, State Frederick, MD	
	21. Signature of Funeral Service Licensed ► Richard E. J. May		22. Name and Address of Facility Kaeney and Basford PA Funeral Home 106 East Church St., Frederick, MD 21701				
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <u>NON SMALL CELL LUNG CANCER</u> Due to (or as a consequence of): <u>METASTATIC LESION TO BRAIN</u> b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. _____						
	Approximate Interval Between Onset and Death						
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last						
	23b. If FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown						
	23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) _____ 9 <input type="checkbox"/> Unknown						
	23d. Date of delivery Month Day Year						
Medical Certification: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						
	23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown						
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						
	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						
	26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide						
	28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 28d. Describe how injury occurred						
	28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)						
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.						
	29b. Signature and title of certifier ► SIBY A. KAZMI, MD APR 16 2007						
	29c. License number D 47951						
	29d. Date signed (Month, Day, Year) 4-8-2007						
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SIBY A. KAZMI, MD 814 TALL HOUSE AVE. FREDERICK, MD 21701						
	31. Date filed (Month, Day, Year) APR 16 2007						
	32. Registrar's Signature SIBY A. KAZMI, MD APR 16 2007						

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division or Vital Records, P.O. Box 68760, Baltimore, MD 21268-0760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit slip.

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 12027

1- For State Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Leonard John Bowers					2. Date of Death Month April Day 8 Year 2007	3. Time of Death 01:55 AM	
Funeral Director	4a. Facility Name (If not institution, give street and number) Upper Chesapeake Medical Center			4b. City, Town, or Location of Death Bel- Air		4c. County of Death Harford		
To Be Completed by Funeral Director	5. Social Security Number 218-32-3794		6. Sex 1 M 2 F	7. Age (In yrs. last birthday) 75 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Hours	8. Date of Birth (Month, Day, Year) Aug. 15, 1931	9. Birthplace (State or Foreign Country) Maryland
	10a. State MD		10b. County Harford		10c. City, Town or Location Aberdeen			10d. Inside City Limits 1 Yes 2 No
	10e. Street and Number 35 Paradise Rd.			10f. Zip Code 21001			10g. Citizen of What Country? U.S.A	
	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 □ No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No) 1 □ Yes 2 □ No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Supervisor		16b. Kind of Business/Industry Manufacturing			
	17. Father's Name (First, Middle, Last) Milton Bowers				18. Mother's Name (First, Middle, Maiden Surname) Mary Strahlen			
Physician /Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Mike Bowers (son)			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9 Manor Knoll Court Baldwin, Maryland 21013				
	20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) R.A. Ferris & Co.		20b. Place of Disposition (Name of cemetery, crematory or other place) R.A. Ferris & Co.		Date 4/10/2007	20c. Location - City or Town, State West Chester, PA		
	21. Signature of Funeral Service Licensee ► Plaza C. Bellman		22. Name and Address of Facility Mitchell-Smith Funeral Home, P.A.		123 S. Washington St. Havre de Grace, MD 21078			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Ischemic Right Leg							
	Approximate Interval Between Onset and Death							
	<p>a. Due to (or as a consequence of): Ischemic Right Leg</p> <p>b. Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. Due to (or as a consequence of):</p>							
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify) 9 □ Unknown		23d. Date of delivery Month Day Year			
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Ischemic Heart Disease Diabetes							
	23e. Did tobacco use contribute to the cause of death? 1 □ Yes 2 □ No 3 □ Probably 4 □ Unknown							
	<p>24a. Was an autopsy performed? 1 □ Yes 2 □ No</p> <p>24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No</p>							
	25. Was case referred to medical examiner? 1 □ Yes 2 □ No		26. Place of Death (Check only one) Hospital: 1 □ Inpatient 2 □ ER/Outpatient 3 □ DOA Other: 4 □ Nursing Home 5 □ Residence 6 □ Other (Specify)					
	27. Manner of Death 1 □ Natural 2 □ Accident 3 □ Suicide 4 □ Homicide		28a. Date of Injury (Month, Day Year) 28b. Time of Injury M		28c. Injury at Work? 1 □ Yes 2 □ No	28d. Describe how injury occurred		
	5 □ Pending investigation 6 □ Could not be determined		28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) 1 □ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 □ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29c. License number D0059855		29d. Date signed (Month, Day, Year) April 8, 2007			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Qinglin Gao, M.D. 500 Upper Chesapeake Dr. Bel Air, MD 21014							
	31. Date filed (Month, Day, Year) APR 16 2007		32. Registrar's Signature James B. Smith					

12844
Bowers, Leonard
Baltimore, Maryland 21215-0036
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or items 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

4/8/07 0155 AM
Division or Vital Records, P.O. Box 68760, 45

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

State Registrar
10

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 12028

1 - For State Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Deanna Bowens							2. Date of Death Month Day Year March 27, 2007	3. Time of Death 12:10 a M						
	4a. Facility Name (If not institution, give street and number) Holy Cross Hospital				4b. City, Town, or Location of Death Silver Spring			4c. County of Death Montgomery							
Funeral Director	5. Social Security Number 092-62-3587		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 42 Yrs.	If Under 1 Year Months Days Hours Min.	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Sept. 23, 1964	9. Birthplace (State or Foreign Country) New York							
	Usual Residence of Decedent Maryland		10a. State Maryland		10b. County Montgomery			10c. City, Town or Location Silver Spring		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
To Be Completed by Funeral Director	10e. Street and Number 3718 Lamberton Square Road, #1716				10f. Zip Code 20904			10g. Citizen of What Country? United States							
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: Black							
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Sales Assistant			16b. Kind of Business/Industry Retail								
17. Father's Name (First, Middle, Last) Jan Bowens					18. Mother's Name (First, Middle, Maiden Surname) Shirley Shane										
19a. Informant's Name/Relationship (Type, Print) Mrs. Shirley Bowens-Mother					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 276 Lynwood Avenue, #144, Buffalo, NY 14209										
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <i>[Signature]</i>			20b. Place of Disposition (Name of cemetery, crematory or other place) Fort Lincoln Crematory			Date 3/30/2007	20c. Location - City or Town, State Brentwood, Maryland								
21. Signature of Funeral Service Licensee <i>[Signature]</i>					22. Name and Address of Facility Simple Tribute Funeral and Cremation Center 1040 Rockville Pike, Rockville, Maryland 20852										
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Pneumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Human Immunodeficiency Virus Acute Renal Failure										Approximate Interval Between Onset and Death					
a. Due to (or as a consequence of): Pneumonia b. Due to (or as a consequence of): Human Immunodeficiency Virus c. Due to (or as a consequence of): Acute Renal Failure d.															
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome pf pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____ <input type="checkbox"/> Unknown							23d. Date of delivery Month Day Year						
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Hypertension										23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No			
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)			28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred			28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29c. License number D60826							29d. Date signed (Month, Day, Year) March 28, 2007						
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kshama Garg, M.D. - 1500 Forest Glen Road, Silver Spring, Maryland 20910															
31. Date filed (Month, Day, Year) APR 02 2007		32. Registrar's Signature <i>[Signature]</i>													

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
 Important: If item 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2007 | 2029
Reg. No.

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Vincent John Bosak					2. Date of Death Month Day Year March 30, 2007	3. Time of Death a.m. 4:30		
	4a. Facility Name (If not institution, give street and number) Laurel Regional Hospital			4b. City, Town, or Location of Death Laurel		4c. County of Death Prince George's			
Funeral Director	5. Social Security Number 203-03-7594		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 87 Yrs.	If Under 1 Year Months Days Hours Min.	8. Date of Birth (Month, Day, Year) Dec. 8, 1919	9. Birthplace (State or Foreign Country) Pennsylvania		
	Usual Residence of Decedent 10a. State Maryland		10b. County Prince George's		10c. City, Town or Location Silver Spring		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
To Be Completed by Funeral Director	10e. Street and Number 3144 Gracefield Road, #207		10f. Zip Code 20904		10g. Citizen of What Country? USA				
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: 1942-45		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. White		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Administrator		16b. Kind of Business/Industry Federal Government				
	17. Father's Name (First, Middle, Last) John Walter Bosak		18. Mother's Name (First, Middle, Maiden Surname) Anna Bushko						
	19a. Informant's Name/Relationship (Type, Print) Judith M. Bosak/Wife		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3144 Gracefield Road, #207, Silver Spring, MD 20904						
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) Fort Lincoln Cemetery		20b. Place of Disposition (Name of cemetery, crematory or other place) April 2, 2007		20c. Location - City or Town, State Brentwood, Maryland				
	21. Signature of Funeral Service Licensee Andrew J. Cole		22. Name and Address of Facility Francis J. Collins Funeral Home Inc 500 University Blvd, W., Silver Spring, MD 20901						
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							Approximate Interval Between Onset and Death 3 Years	
	<p>a. Advanced Interstitial Pulmonary Fibrosis Due to (or as a consequence of):</p> <p>b. Chronic Obstructive Pulmonary Disease Due to (or as a consequence of):</p> <p>c. _____ Due to (or as a consequence of):</p> <p>d. _____</p>								
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome pf pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown <input type="checkbox"/> Other (specify) _____		23d. Date of delivery Month Day Year				
Medical Certification: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
								24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred			
			28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
	29b. Signature and title of certifier Loveen Puthumana, MD		29c. License number D59524		29d. Date signed (Month, Day, Year) March 30, 2007				
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Loveen J. Puthumana, M.D. 3110 Gracefield Road, Silver Spring, MD 20904								
State Registrar	31. Date filed (Month, Day, Year) APR 02 2007		32. Registrar's Signature Loveen J. Puthumana						

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division or Vital Records, P.O. Box 68760,

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 12030

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) William Barnaby Berard, Jr.							2. Date of Death Month Month Day Year March 29, 2007	3. Time of Death 1:30 p M
	4a. Facility Name (If not institution, give street and number) Montgomery General Hospital			4b. City, Town, or Location of Death Olney			4c. County of Death Montgomery		
Funeral Director	5. Social Security Number 226-42-8646	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 67 Yrs.	If Under 1 Year Months Days Hours Min.	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) June 16, 1939	9. Birthplace (State or Foreign Country) District of Columbia		
	Usual Residence of Decedent 10a. State Maryland 10b. County Montgomery			10c. City, Town or Location Olney			10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
To Be Completed by Funeral Director	10e. Street and Number 11714 Coatbridge Place			10f. Zip Code 20832			10g. Citizen of What Country? U.S.A.		
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: White			14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 2		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Graphic Artist		16b. Kind of Business/Industry Graphic Art				
	17. Father's Name (First, Middle, Last) William Barnaby Berard, Sr.				18. Mother's Name (First, Middle, Maiden Surname) Grace Mae Fitchette				
	19a. Informant's Name/Relationship (Type, Print) Mary Lynne Berard - Spouse			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11714 Coatbridge Place, Olney, Maryland 20832					
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Columbia Gardens Cemetery		Date 4/2/2007	20c. Location - City or Town, State Arlington, Virginia			
	21. Signature of Funeral Service Licensee Nancy A. Peacock								
	22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Avenue, Silver Spring, Maryland 20904								
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								
Medical Certification: To Be Completed by Physician/Medical Examiner	23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown 23c. If yes, outcome pf pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) _____ 9 <input type="checkbox"/> Unknown 23d. Date of delivery Month Day Year								
	23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown								
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No								
	25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)								
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 28d. Describe how injury occurred 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)								
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier J. M. D. 29c. License number P0058770 29d. Date signed (Month, Day, Year) March 29, 2007								
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jeremy Gref 18101 Prince Philip Dr. Olney, Maryland 20832								
State Registrar	31. Date filed (Month, Day, Year) APR 02 2007	32. Registrar's Signature Barbara B. Smith							

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

10

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2007 12031
Reg. No.

1 - For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Milagros Buenaventura Hernandez Bell-Rodriguez						2. Date of Death Month Day Year April 1, 2007	3. Time of Death 6:50 p M	
	4a. Facility Name (If not institution, give street and number) Citizens Care Center			4b. City, Town, or Location of Death Havre de Grace			4c. County of Death Harford		
Funeral Director	5. Social Security Number 583-62-2134	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 92 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) April 19, 1914	9. Birthplace (State or Foreign Country) Puerto Rico		
	Usual Residence of Decedent 10a. State Maryland			10b. County Harford			10c. City, Town or Location Churchville		
10e. Street and Number 3425 McCommons Road				10f. Zip Code 21028			10g. Citizen of What Country? U.S.A.		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: 1914			13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Specify: Puerto Rican			14. Race - American Indian, Black, White, etc. Specify: Hispanic	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Four Years Homemaker			16b. Kind of Business/Industry Personal Residence			
17. Father's Name (First, Middle, Last) Esteban Hernandez				18. Mother's Name (First, Middle, Maiden Surname) Primitiva Bell					
19a. Informant's Name/Relationship (Type, Print) Edda M. Ruiz (Daughter)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 566, Aberdeen, Maryland 21001			Date 04/04/07		20c. Location - City or Town, State West Chester, Pennsylvania		
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) R.A. Ferris & Co., Inc.						20b. Place of Disposition (Name of cemetery, crematory or other place) Lee A. Patterson & Son Funeral Home, P.A. Perryville, Maryland 21903-0766			
21. Signature of Funeral Service Licensee Johns H. Patterson, Jr.						22. Name and Address of Facility Lee A. Patterson & Son Funeral Home, P.A. Perryville, Maryland 21903-0766			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Coronary Artery Disease						Approximate Interval Between Onset and Death >10 yrs.			
<p>a. Due to (or as a consequence of): Coronary Artery Disease</p> <p>b. Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. Due to (or as a consequence of):</p>									
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year				
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Chronic Renal Failure congestive Heart Failure						23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide				
28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29c. License number D15994			29d. Date signed (Month, Day, Year) 4-2-07				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LETICIA S. GALVEZ, M.D. 625 S-UNION AVE HAVRE DE GRACE MD.						31. Date filed (Month, Day, Year) APR 3 2007			32. Registrar's Signature Heather H. Gandy

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 12032

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Marie Elizabeth Bell					2. Date of Death Month 03 Day 29 Year 07 07:30 AM	3. Time of Death	
	4a. Facility Name (If not institution, give street and number) Peninsula Regional Medical Center		4b. City, Town, or Location of Death Salisbury			4c. County of Death Wicomico		
Funeral Director	5. Social Security Number 219-36-5229	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 64 Yrs.	If Under 1 Year Months 0 Days 0 Hours 0 Min. 0	8. Date of Birth (Month, Day, Year) July 22, 1942	9. Birthplace (State or Foreign Country) South Carolina		
	Usual Residence of Decedent 10a. State Maryland 10b. County Wicomico		10c. City, Town or Location Salisbury			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
To Be Completed by Funeral Director	10e. Street and Number 1514 Riverside Drive, A203			10f. Zip Code 21801		10g. Citizen of What Country? USA		
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: Specify: Black		14. Race - American Indian, Black, White, etc.		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) laborer			16b. Kind of Business/Industry		
	17. Father's Name (First, Middle, Last) Joseph Andrade			18. Mother's Name (First, Middle, Maiden Surname) Thelma Hall				
	19a. Informant's Name/Relationship (Type, Print) Sherrie C. Corbin/daughter		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 28277 Altman CT - Salisbury, Maryland 21801			20c. Location - City or Town, State Salisbury, Maryland		
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) Patricia A. Jolley		20b. Place of Disposition (Name of cemetery, crematory or other place) Salisbury Crematory		Date April 4, 2007	20c. Location - City or Town, State Salisbury, Maryland		
	21. Signature of Funeral Service Licensee Patricia A. Jolley		22. Name and Address of Facility 1213 Jersey Road - Salisbury, MD JOLLEY MEMORIAL CHAPEL, P. A.					
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) pneumonia Approximate Interval Between Onset and Death 4wks							
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last laryngeal carcinoma							
	a. Due to (or as a consequence of): pneumonia							
	b. Due to (or as a consequence of): laryngeal carcinoma							
	c. Due to (or as a consequence of):							
	d. Due to (or as a consequence of):							
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome pf pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year		
Medical Certification: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
	23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown							
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No							
	25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred		
			28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
	29b. Signature and title of certifier Chris Snyder				29c. License number H50497		29d. Date signed (Month, Day, Year) 3/29/07	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Chris Snyder 100 E. Carroll St. Salisbury Md. 21801							
State Registrar	31. Date filed (Month, Day, Year) APR 02 2007	32. Registrar's Signature Please be seated						

Marie Bell 219-36-5229
Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2007 12033
Reg. No.

1- For
State
Registrar

Physician
/Medical
Examiner

Funeral
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
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To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transit

State
Registrar

Medical Certification: To Be Completed by Physician/Medical Examiner

Anna Marie Clark
Division of Vital Records, P.O. Box 68760, US

1. Decedent's Name (First, Middle, Last)	ANNA MARIE CLARK			2. Date of Death Month April Day 8 Year 2007	3. Time of Death 6:15 AM	
4a. Facility Name (If not institution, give street and number)		Bel Air Nursing Center			4b. City, Town, or Location of Death Bel Air, MD	
5. Social Security Number	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (in yrs. last birthday) 93 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days Hours Min.	8. Date of Birth (Month, Day, Year) 10/24/1913	
10a. State MD.		10b. County Harford	10c. City, Town or Location Forest Hill			
10e. Street and Number 1721 Belvue Drive			10f. Zip Code 21050	10g. Citizen of What Country? United States		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Specify Yes or No) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 3	16b. Kind of Business/Industry Telephone Operator Answering Service			
17. Father's Name (First, Middle, Last) Albert Monroe Griffin			18. Mother's Name (First, Middle, Maiden Surname) Margaret Lautenschleiger			
19a. Informant's Name/Relationship (Type, Print) Christine Ohler (Daughter) 1721 Belvue Drive Forest Hill, Md.			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21050			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) Monkton Meth. Cem.		20b. Place of Disposition (Name of cemetery, crematory or other place)	Date 4/13/2007		20c. Location - City or Town, State Monkton, Maryland	
21. Signature of Funeral Service Licensee M. Bladden Kurtz		22. Name and Address of Facility Jarrettsville, Maryland E.G. Kurtz & Son Funeral Home, P.A.				
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)			Approximate Interval Between Onset and Death Advanced Dementia with failure to Thrive			
b. Due to (or as a consequence of):						
c. Due to (or as a consequence of):						
d. Due to (or as a consequence of):						
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown	23d. Date of delivery Month Day Year		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Cther: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide			28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred
				M		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State)
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.			29c. License number D19583			29d. Date signed (Month, Day, Year) April 8, 2007
29b. Signature and title of certifier Manuel Lazarin MD			29c. Registrar's Signature John S. Spaulding			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Manuel Lazarin MD 8 Law Street, Aberdeen, Maryland						
31. Date filed (Month, Day, Year) APR 16 2007						

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit permit.

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM 24a, 26, per V.E.R.B., G866, 4/16/07, WS

State of Maryland / Département of Health and Mental Hygiene 2007 12034

Certificate of Death

Reg. No.

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last)					2. Date of Death	3. Time of Death			
	Ann Campbell					Month Day Year 07 05 2007 2014 M				
Funeral Director	4a. Facility Name (If not institution, give street and number)			4b. City, Town, or Location of Death		4c. County of Death				
	Howard County General Hospital			Columbia		Howard				
To Be Completed by Funeral Director	5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	9. Birthplace (State or Foreign Country)			
	151-01-1499	1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	94 Yrs.	Months Days	Hours Min.	(Month, Day, Year) May 30, 1912	Germany			
Usual Residence of Decedent										
10a. State	10b. County	10c. City, Town or Location					10d. Inside City Limits			
Maryland	Howard	Ellicot City					1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
10e. Street and Number				10f. Zip Code		10g. Citizen of What Country?				
5330 Dorsey Hall Drive				21042		U.S.A.				
11. Marital Status		12. Was Decedent Ever in U.S. Armed Forces?			13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)			14. Race - American Indian, Black, White, etc.		
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:			1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			Specify: White		
15. Decedent's Education (Specify only highest grade completed)			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)			16b. Kind of Business/Industry				
Elementary/Secondary (0-12) 12			College (1-4 or 5+) Beverage/Food Manager			Hotel Industry				
17. Father's Name (First, Middle, Last)		18. Mother's Name (First, Middle, Maiden Surname)								
Fritz		Grundmann Freida					Hilscher			
19a. Informant's Name/Relationship (Type, Print)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)								
R. Bruce Campbell, Son		4968 Pintail Court, Frederick, Maryland 21703								
20a. Method of Disposition		20b. Place of Disposition (Name of cemetery, crematory or other place)			Data		20c. Location - City or Town, State			
1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		Smithsburg Crematory			Apr 7, 2007		Smithsburg, Maryland			
21. Signature of Funeral Service Licensee		22. Name and Address of Facility								
Kathleen L. Benson MO0706		Keeney & Basford P.A. Funeral Home 106 East Church St, Frederick, Maryland 21701								
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.								Approximate Interval Between Onset and Death		
Immediate Cause (Final disease or condition resulting in death)								1 week		
a. Due to (or as a consequence of): Congestive Heart Failure								1 week		
b. Due to (or as a consequence of): Cardiomyopathy								1 week		
c. Due to (or as a consequence of): Renal Failure								1 week		
d.										
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown								23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 4 <input type="checkbox"/> Pregnant at time of death 9 <input type="checkbox"/> Unknown	3 <input type="checkbox"/> Ectopic pregnancy 5 <input type="checkbox"/> Other (Specify)	23d. Date of delivery Month Day Year
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		
								24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								26. Place of Death (Check only one)		
Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA								Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred				
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)								28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								29d. Date signed (Month, Day, Year)		
29b. Signature and title of certifier Dale L. no								29c. License number 058842		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ann Campbell 8186 Lakeview Rd, Bridge no 21075								29d. Date signed (Month, Day, Year) 4/10/07		
31. Date filed (Month, Day, Year)		32. Registrar's Signature								
APR 16 2007		John J. Spialek								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2007 12035

Reg. No.

1- For
State
Registrar

Physician
/Medical
Examiner

Funeral
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

Important: If item 27 is marked other than "natural", or Items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or Items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

1. Decedent's Name (First, Middle, Last)							2. Date of Death Month Day Year	3. Time of Death a.m./p.m.
Ida S. Casey							March 28, 2007	8:15 a.m.
4a. Facility Name (If not institution, give street and number)			4b. City, Town, or Location of Death			4c. County of Death		
Wilson Health Care at Asbury Village			Gaithersburg			Montgomery		
5. Social Security Number	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) Yrs. 90	If Under 1 Year Months	If Under 24 Hrs. Days	Hours	Min.	8. Date of Birth (Month, Day, Year) Jan. 31, 1917	9. Birthplace (State or Foreign Country) Illinois
Usual Residence of Decedent								
10a. State Maryland	10b. County Montgomery	10c. City, Town or Location Gaithersburg						10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
10e. Street and Number 211 Russell Avenue			10f. Zip Code 20877			10g. Citizen of What Country? USA		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No.) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. White	
15. Decedent's Education (Specify only highest grade completed) Elementary School (0-12) 12			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Health Technician			16b. Kind of Business/Industry County Government		
17. Father's Name (First, Middle, Last) Edward Wyatt Boyd				18. Mother's Name (First, Middle, Maiden Surname) Julia Evaline Monroe				
19a. Informant's Name/Relationship (Type, Print) Dara F. Castle/Granddaughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 433 Lakelands Drive, Gaithersburg, MD 20878				
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Metropolitan Crematory			Date March 29	20c. Location - City or Town, State Alexandria, Virginia	
21. Signature of Funeral Service Licensee ► Steven J. Olszynski								
22. Name and Address of Funeral Home Inc. Francis J. Collins Funeral Home Inc. 500 University Blvd, W, Silver Spring, MD 20901								
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) dementia								
Approximate Interval Between Onset and Death years								
23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown								
23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Unknown								
23d. Date of delivery Month Day Year								
23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown								
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No								
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide								
28a. Date of Injury (Month, Day, Year)			28b. Time of Injury M			28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		
28d. Describe how injury occurred								
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)								
28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier ► Steven J. Olszynski								
29c. License number D-20148								
29d. Date signed (Month, Day, Year) March 28, 2007								
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Steven J. Olszynski MD 911 Russell Ave. Gaithersburg Md.								
31. Date filed (Month, Day, Year) APR 02 2007			32. Registrar's Signature Rebecca B. Joseph					

ORIGINAL

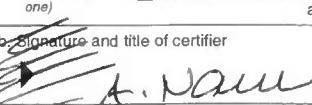
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registration
MEND#20openH4/2/07,bMW,Mcoo

Certificate of Death

Reg. No. 2007 12036

Physician /Medical Examiner Funeral Director To Be Completed by Funeral Director		<p align="center">Certificate of Death</p> <p>1. Decedent's Name (First, Middle, Last) Mary Dolores Curtis</p> <p>4a. Facility Name (If not institution, give street and number) Washington Adventist Hospital</p> <p>4b. City, Town, or Location of Death Takoma Park</p> <p>2. Date of Death Month March Day 28, Year 2007</p> <p>3. Time of Death 2205 M</p> <p>4c. County of Death Montgomery</p> <p>5. Social Security Number 577-07-9530</p> <p>6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F</p> <p>7. Age (In yrs. last birthday) 91 Yrs.</p> <p>If Under 1 Year If Under 24 Hrs. Months Days Hours Min.</p> <p>8. Date of Birth (Month, Day, Year) June 16, 1915</p> <p>9. Birthplace (State or Foreign Country) Pennsylvania</p> <p>10a. State Maryland</p> <p>10b. County Montgomery</p> <p>10c. City, Town or Location Silver Spring</p> <p>10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>10e. Street and Number 8921 Whitney Street</p> <p>10f. Zip Code 20901</p> <p>10g. Citizen of What Country? U.S.A.</p> <p>11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced</p> <p>12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:</p> <p>13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: White</p> <p>14. Race - American Indian, Black, White, etc. White</p> <p>15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12</p> <p>16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker</p> <p>16b. Kind of Business/Industry Own Home</p> <p>17. Father's Name (First, Middle, Last) Charles Pilotti</p> <p>18. Mother's Name (First, Middle, Maiden Surname) Berta Beltran</p> <p>19a. Informant's Name/Relationship (Type, Print) William P. Curtis - Son</p> <p>19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3112 Circle Hill Road, Alexandria, Virginia 22305</p> <p>20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) Fort Lincoln Crematory</p> <p>20b. Place of Disposition (Name of cemetery, crematory or other place) Fort Lincoln Crematory</p> <p>Date 4-6-2007</p> <p>20c. Location - City or Town, State Brentwood, Maryland</p> <p>21. Signature of Funeral Service licensee </p> <p>22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Avenue, Silver Spring, Maryland 20904</p> <p>23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death</p> <p>Immediate Cause (Final disease or condition resulting in death) Acute Renal Failure days</p> <p>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</p> <p>a. Due to (or as a consequence of): Sepsis days</p> <p>b. Due to (or as a consequence of): Ischemia of bowel days</p> <p>c. Due to (or as a consequence of): </p> <p>d. </p> <p>IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown</p> <p>23c. If yes, outcome pf pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown <input type="checkbox"/> Other (Specify)</p> <p>23d. Date of delivery Month Day Year</p> <p>Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.</p> <p>23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown</p> <p>24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)</p> <p>27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide</p> <p>28a. Date of Injury (Month, Day Year) </p> <p>28b. Time of Injury M</p> <p>28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>28d. Describe how injury occurred</p> <p>28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)</p> <p>28f. Location (Street and Number or Rural Route Number, City or Town, State)</p> <p>29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.</p> <p>29b. Signature and title of certifier  A. NAWAZ MD</p> <p>29c. License number D50987</p> <p>29d. Date signed (Month, Day, Year) 3-30-07</p> <p>30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AHMED NAWAZ P.O Box 83819 Gaithersburg MD 20883.</p> <p>31. Date filed (Month, Day, Year) APR 02 2007</p> <p>32. Registrar's Signature </p>					
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Baltimore, Maryland 21215-0036

Important: If item 27 is marked other than "natural", or items 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2007 12037

1. For State
Registrar**Physician/
Medical Examiner**

1. Decedent's Name (First, Middle, Last)

Bertha A. Coleman

Reg. No.

2. Date of Death

Month Day Year
April 1, 2007

3. Time of Death

1640 hrs

**Funeral
Director**

4a. Facility Name (if not institution, give street and number)

260-A Hilltop Lane Apartment 203

4b. City, Town, or Location of Death

Annapolis

4c. County of Death

Anne Arundel

5. Social Security Number

214-54-8007

6. Sex

 M F

7. Age (in yrs. last birthday)

58 Yrs.

If Under 1 Year

Months

Days

Hours

Min.

8. Date of Birth (MM/DD/YYYY)

Jan 25 1949

9. Birthplace (State or
Foreign Count)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Anne Arundel

10c. City, Town or Location

Annapolis

10d. Inside City Limits

 Yes No

10e. Street and Number

260 A Hilltop Lane Apt 203

10f. Zip Code

21403

10g. Citizen of What Country?

USA

11. Marital Status

1 Never Married2 Married3 Widowed4 Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 Yes2 NoIf Yes, Give Year
or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 Yes2 No

specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12th

College (1-4 or 5+)

2yrs

16a. Decedent's Usual Occupation (Give kind of work done
during most of working life. DO NOT use retired)

Health Care Administrator

16b. Kind of Business/Industry

Anne Arundel Medical Center

17. Father's Name (First, Middle, Last)

Isaiah Jones

18. Mother's Name (First, Middle, Maiden Surname)

Hazel Peters

19a. Informant's Name/Relationship (Type, Print.)

Darlene Leonard (Sister)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21090

438 Hillview Dr Apt 204 Linthicum Hgts, Md.

20a. Method of Disposition

1 Burial2 Cremation3 Removal from State4 Donation5 Other Specify:20b. Place of Disposition (Name of cemetery,
crematory or other place)

Moses Cemetery

Date

4-12-07

20c. Location - City or Town, State

Drury, Md.

21. Signature of Funeral Service Licensee

Larry G. Reese moco 487

21a. Name and Address of Facility

W.M. Reese & Sons Mortuary, P.A.

821 West St. Annapolis, Md. 21401

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval
Between Onset and
DeathImmediate Cause (Final disease
or condition resulting in death)

a. Hypertensive heart disease

Due to (or as a consequence of):

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

 UNPENDED AMENDED #23a, PII, 27, per ME, g866, 4/26/07 TT**Division of Vital Records, P.O. Box 68760,**

To the Physician or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 9 Unknown

23c. If yes, outcome of pregnancy

1 Live birth2 Fetal death3 Ectopic pregnancy4 Pregnant at time of death5 Other (Specify)9 Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions

contributing to death but not resulting in the underlying cause given in Part I.

Diabetes mellitus

23e. Did tobacco use contribute to the cause of death?

1 Yes 2 No 3 Probably 4 Unknown

25. Was case referred to medical examiner?

1 Yes2 No

Hospital

1 Inpatient2 ER/Outpatient3 DOA4 Nursing Home5 Residence6 Other: Scene

26. Place of Death (Check only one)

1 Natural2 Accident3 Suicide4 Homicide5 Pending Investigation6 Could not be determined

27. Manner of Death

28a. Date of Injury
(Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 Yes 2 No

28d. Describe how injury occurred

29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
one
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

Patricia Aronica-Pollak MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

April 2, 2007

State
Registrar

31. Date filed (Month, Day, Year)

APR 11 2007

32. Registrar's Signature

James M. Gandy

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 12038

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Betty Jane Carson							2. Date of Death Month Day Year APRIL 1, 2007	3. Time of Death 1:15 A M
	4a. Facility Name (If not institution, give street and number) CIVISTA MEDICAL CENTER			4b. City, Town, or Location of Death LAPLATA			4c. County of Death CHARLES		
Funeral Director	5. Social Security Number 199-24-7688	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 74 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) July 22, 1932	9. Birthplace (State or Foreign Country) Pennsylvania		
	Usual Residence of Decedent Maryland Charles		10c. City, Town or Location Waldorf			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
10e. Street and Number 11080 Weymouth Ct.				10f. Zip Code 20603			10g. Citizen of What Country? US		
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: White			14. Race - American Indian, Black, White, etc. Specify: White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Waitress			16b. Kind of Business/Industry Restaurant		
17. Father's Name (First, Middle, Last) Kenneth Muth				18. Mother's Name (First, Middle, Maiden Surname) Ethel R. Carson					
19a. Informant's Name/Relationship (Type, Print) Thomas Elam - friend				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2100 Brooks Dr. #714, District Heights, MD 20747					
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Huntt Crematory			Date 04-03-2007	20c. Location - City or Town, State Waldorf, MD		
21. Signature of Funeral Service Licensee 			22. Name and Address of Facility Huntt Funeral Home			3035 Old Washington Rd Waldorf, MD 20601			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Approximate Interval Between Onset and Death 2 days < 1 week < 1 week.									
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome pf pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown						23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 									
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DDA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide			28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred			
			28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.			29b. Signature and title of certifier 						
			29c. License number D-46419			29d. Date signed (Month, Day, Year) 4/1/07			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CHARLENE LETCHFORD 404 E. CHARLES STREET LAPLATA, MD 20646									
31. Date filed (Month, Day, Year) APR 03 2007			32. Registrar's Signature 						

CARSON, BETTY

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

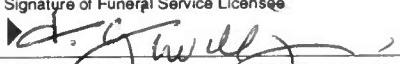
Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

1- For State Registrar		State of Maryland / Department of Health and Mental Hygiene		Amend Item 26 per dr., g866, 04/18/07 dhb Certificate of Death		Reg. No. 2007 12039
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Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Charles Edward Cropper					2. Date of Death Month Day Year March 26, 2007	3. Time of Death 2:45 PM	
	4a. Facility Name (If not institution, give street and number) 10691 Norris Twilley Road		4b. City, Town, or Location of Death Delmar			4c. County of Death Wicomico		
Funeral Director	5. Social Security Number 230-48-1255	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 67 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Aug. 7, 1939	9. Birthplace (State or Foreign Country) Pennsylvania	
	Usual Residence of Decedent MD Wicomico		10c. City, Town or Location Delmar			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
To Be Completed by Funeral Director	10e. Street and Number 10691 Norris Twilley Road			10f. Zip Code 21875		10g. Citizen of What Country? U.S.A.		
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: 1956- 1959	13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:	14. Race - American Indian, Black, White, etc. Specify: White				
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 7	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+)	16b. Kind of Business/Industry Pump Tester	16c. Kind of Business/Industry Pump Manufacturer				
	17. Father's Name (First, Middle, Last) William Cropper	18. Mother's Name (First, Middle, Maiden Surname) Margie Birch						
	19a. Informant's Name/Relationship (Type, Print) Barbara Faye Cropper (wife)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10691 Norris Twilley Rd. Delmar, MD 21875						
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)	20b. Place of Disposition (Name of cemetery, crematory or other place) Crematory of Delmarva	Date 3-28-2007	20c. Location - City or Town, State Delmar, Delaware				
	21. Signature of Funeral Service Licensee 	22. Name and Address of Facility Short Funeral Home 13 E. Grove St. Delmar, DE 19940						

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0036
permits. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a show any injury or other traumatic event, the Medical Examiner must be notified at

Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Metastatic Lung Cancer					Approximate Interval Between Onset and Death			
	<p>a. Due to (or as a consequence of): Metastatic Lung Cancer</p> <p>b. Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. Due to (or as a consequence of):</p>								
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown	23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year				
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					23e. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA			26. Place of Death (Check only one) Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide	28a. Date of Injury (Month, Day Year)		28b. Time of Injury	28c. Injury at Work? M 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred			
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.	29c. License number D26278			29d. Date signed (Month, Day, Year) 3-29-07				
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) David E. Cocco, MD Coastal Hospice PO Box 1733 Seaford, MD 21802								
	31. Date filed (Month, Day, Year) MAR 30 2007	32. Registrar's Signature Please be seated							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

1- For State Registrar Amend Items 25, 27, 28a-f per me, 8806, 04/26/07/db
23a. State of Maryland / Department of Health and Mental Hygiene
23b. Certificate of Death

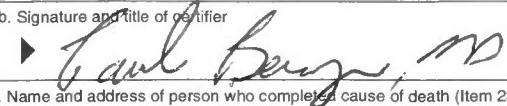
Reg. No. 2007 42040

Physician / Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>Gene Carey</i>							2. Date of Death Month 03 Day 29 Year 2007	3. Time of Death 7:25 PM	
	4a. Facility Name (If not institution, give street and number) <i>Deer's Head Hospital Cents</i>				4b. City, Town, or Location of Death <i>Salisbury</i>			4c. County of Death <i>Wicomico</i>		
Funeral Director	5. Social Security Number <i>218-58-0297</i>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <i>57 Yrs.</i>	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <i>Dec. 8, 1949</i>	9. Birthplace (State or Foreign Country) <i>Maryland</i>		
	10a. State <i>MD</i>		10b. County <i>Wicomico</i>		10c. City, Town or Location <i>Salisbury</i>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
To Be Completed by Funeral Director	10e. Street and Number <i>351 Deer's Head Hospital Road</i>				10f. Zip Code <i>21801</i>		10g. Citizen of What Country? <i>U.S.A.</i>			
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: <i>2004</i>		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: <i>white</i>			14. Race - American Indian, Black, White, etc. Specify: <i>white</i>			
15. Decedent's Education (Specify only highest grade completed) <i>Elementary/Secondary (0-12) 11</i>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>College (1-4 or 5+) Roofer</i>		16b. Kind of Business/Industry <i>Roofing</i>						
17. Father's Name (First, Middle, Last) <i>Lester D. Carey, Sr.</i>		18. Mother's Name (First, Middle, Maiden Surname) <i>Annie Savage</i>								
19a. Informant's Name/Relationship (Type, Print) <i>Lester Carey (Brother)</i>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>1007 Grapevine Rd. Mardela Springs, MD 21837</i>								
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <i>Crematory of Delmarva</i>		20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Crematory of Delmarva</i>		Date <i>3/31/2007</i>			20c. Location - City or Town, State <i>Delmar, Delaware</i>			
21. Signature of Funeral Service Licensee <i>Amy Short Jewell</i>		22. Name and Address of Facility <i>Short Funeral Home 13 E. Grove St. Delmar, DE 19940</i>								
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <i>Sepsis with pneumonia</i>		23b. Due to (or as a consequence of): <i>Aspiration</i>		Approximate Interval Between Onset and Death <i>hours</i>						
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <i>9 Unknown</i>		23d. Date of delivery Month Day Year						
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		23f. Date of delivery Month Day Year						
23g. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Persistent vegetative state due to subdural hematoma</i>		23h. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		23i. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) <i>Unknown</i>		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide			28a. Date of Injury (Month, Day, Year) <i>Unknown</i>	28b. Time of Injury <i>Unknown</i>	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <i>Unknown</i>	28d. Describe how injury occurred <i>Unknown</i>
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <i>Gene S. staff physician</i>		29c. License number <i>D0063368</i>			29d. Date signed (Month, Day, Year) <i>03/30/2007</i>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>351 Deer's Head Rd P.O. Box 2018, Salisbury, MD 21802</i>		31. Date filed (Month, Day, Year) <i>APR 02 2007</i>		32. Registrar's Signature <i>Gene S. Carey</i>						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

For Amend#7 Per FH State of Maryland / Department of Health and Mental Hygiene
1 - For State Registrar AAO HEALTH DEPT. 3/30/07 CMH Certificate of Death

Reg. No. 2007 12041

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) James B. Eppes, Jr.				2. Date of Death Month March	Year 28	Time of Death 11:40 PM					
	4a. Facility Name (If not institution, give street and number) Ginger Cove Health Center				4b. City, Town, or Location of Death Annapolis		4c. County of Death Anne Arundel					
Funeral Director	5. Social Security Number 212-10-0325	6. Sex 1 M 2 F	7. Age (In yrs. last birthday) 94-94 Yrs.	If Under 1 Year Months 0	If Under 24 Hrs. Days 0	Hours 0	Min. 0	8. Date of Birth (Month, Day, Year) Jan. 29, 1913	9. Birthplace (State or Foreign Country) Washington DC			
To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State Maryland								10b. County Anne Arundel	10c. City, Town or Location Annapolis	10d. Inside City Limits 1 Yes 2 No	
	10e. Street and Number 1307 River Crescent Drive				10f. Zip Code 21401			10g. Citizen of What Country? U.S.A.				
	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No Specify:			14. Race - American Indian, Black, White, etc. Specify: White				
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 4				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Engineer			16b. Kind of Business/Industry Civil Service				
	17. Father's Name (First, Middle, Last) James B. Eppes				18. Mother's Name (First, Middle, Maiden Surname) Elizabeth K. Williford							
	19a. Informant's Name/Relationship (Type, Print) James B. Eppes, III/son				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 167 Bridgewater Circle Fredericksburg, VA 22406							
	20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Baltimore Crematory			Date 3/31/2007	20c. Location - City or Town, State Baltimore, Maryland			
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility John M. Taylor Funeral Home 147 Duke of Gloucester St., Annapolis, MD 21401							
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Exacerbation of COPD								Approximate Interval Between Onset and Death 2 weeks			
	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown								23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown			
	23d. Date of delivery Month Day								Year			
Medical Certification: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Alzheimers Disease								23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown			
	25. Was case referred to medical examiner? 1 Yes 2 No								26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)			
	27. Manner of Death 1 Natural 5 Pending investigation 2 Accident 6 Could not be determined 3 Suicide 4 Homicide				28a. Date of Injury (Month, Day, Year) 28b. Time of Injury M	28c. Injury at Work? 1 Yes 2 No	28d. Describe how injury occurred					
	28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)								28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.											
	29b. Signature and title of certifier 								29c. License number D0029571			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Paul Berez, MD 2225 E Defense Highway Crofton, MD 21114								29d. Date signed (Month, Day, Year) 3/29/2007			
	31. Date filed (Month, Day, Year) MAR 30 2007				32. Registrar's Signature 							

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2007 12342

1- For State
Registrar

Reg. No.

**Physician/
Medical Examiner**

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Michael Walter Evans, Sr.	April 5, 2007	0740 hrs

**Funeral
Director**

4a. Facility Name (if not institution, give street and number) 514 Crain Highway	4b. City, Town, or Location of Death Glen Burnie	4c. County of Death Anne Arundel
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Permit: Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

5. Social Security Number 214-54-9575	6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) 54	If Under 1 Year Months Days Hours Min.	If Under 24 Hrs. Hours Min.	8. Date of Birth (MM/DD/YYYY) Aug. 15, 1952	9. Birthplace (State or Foreign Country) Maryland
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Baltimore, MD 21215-0036

10a. State Maryland	10b. County Queen Annes	10c. City, Town or Location Centreville	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
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10e. Street and Number 220 Possum Point Farm	10f. Zip Code 21617	10g. Citizen of What Country? U.S.A.
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11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: 1972-76	13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No specify: Specify: White	14. Race - American Indian, Black, White, etc.
---	---	--	--

15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Painter	16b. Kind of Business/Industry Painting Contractor
---	--	--

17. Father's Name (First, Middle, Last) Joseph Charles Evans	18. Mother's Name (First, Middle, Maiden Surname) Irene Gibula
--	--

19a. Informant's Name/Relationship (Type, Print) John J. Evans, Sr./brother	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 220 Possum Point Farm Centreville, MD 21617
---	---

20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other Specify	20b. Place of Disposition (Name of cemetery, crematory or other place) MD Veterans Cemetery	Date 4/12/2007	20c. Location - City or Town, State Crownsville, MD
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21. Signature of Funeral Service Licensee Michelle P. Katta	22. Name and Address of Facility John M. Taylor Funeral Home 147 Duke of Gloucester St., Annapolis, MD 21401
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23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)	a. Blunt force injuries Due to (or as a consequence of):	Approximate Interval Between Onset and Death
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Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):	c. Due to (or as a consequence of):	d. Due to (or as a consequence of):
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<input type="checkbox"/> UNPENDED	<input type="checkbox"/> AMENDED #12a,27,28a-f, perME, g867, 5/7/07 TT
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IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown	23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown	23d. Date of delivery Month Day Year
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Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown
	24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No
	24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No

25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other: Scene		
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27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input checked="" type="checkbox"/> Homicide	28a. Date of Injury (Month, Day, Year) Frd 4/5/2007	28b. Time of Injury Frd 7:30 am	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	28d. Describe how injury occurred subject assaulted
---	---	---	---	---

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) other-scene	28f. Location (Street and Number or Rural Route Number, City or Town, State) 514 Crain Hwy. Glen Burnie, MD
---	---

29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated
--

29b. Signature and title of certifier Zabiullah Ali, M.D.	29c. License number O.C.M.E.	29d. Date signed (Month, Day, Year) April 5, 2007
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30. Name and address of person who completed cause of death (Item 23a) Zabiullah Ali, M.D. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201
--

31. Date filed (Month, Day, Year) APR 11 2007	32. Registrar's Signature [Signature]
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Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
 To the Funeral Director: After this certificate has been signed by the attending physician, it should be detached for use as the burial - transit completely filled in by the funeral director, page 2 should be detached for use as the burial - transit completely filled in by the funeral director.

Medical Certification: To Be Completed by Physician/Medical Examiner

State Registrar	32. Registrar's Signature [Signature]
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar Amend #2 PerPhy G866 4/16/07 JH Certificate of Death

Reg. No.

2007 12043

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Morris Ellwood Fleming							2. Date of Death 06 Month April Day 5 Year 2007	3. Time of Death 12:35 AM
	4a. Facility Name (If not institution, give street and number) Washington County Hospital			4b. City, Town, or Location of Death Hagerstown			4c. County of Death Washington		
Funeral Director	5. Social Security Number 214-09-2152		6. Sex 1 M 2 F	7. Age (In yrs. last birthday) 91 Yrs.	If Under 1 Year Months 8. Date of Birth (Month, Day, Year) June 8, 1915	If Under 24 Hrs. Hours Min.	9. Birthplace (State or Foreign Country) Maryland		
	Usual Residence of Decedent		10a. State Maryland 10b. County Washington 10c. City, Town or Location Hagerstown			10d. Inside City Limits 1 Yes 2 No			
To Be Completed by Funeral Director	10e. Street and Number 1139 Sunnyside Drive			10f. Zip Code 21742			10g. Citizen of What Country? USA		
	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No Specify:			14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Purchasing Agent		16b. Kind of Business/Industry Electronics				
	17. Father's Name (First, Middle, Last) Frederick William Fleming				18. Mother's Name (First, Middle, Maiden Surname) Minnie Ethel Morris				
	19a. Informant's Name/Relationship (Type, Print) Alice R. Fleming/Wife			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1139 Sunnyside Drive, Hagerstown, Md. 21742					
	20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Rest Haven Cemetery			Date 4/9/2007	20c. Location - City or Town, State Hagerstown, Maryland	
	21. Signature of Funeral Service Licensee S. Mark Saenger			22. Name and Address of Facility Rest Haven Funeral Chapel 1601 Pennsylvania Avenue, Hagerstown, Md. 21742					
Physician /Medical Examiner	23a. Part I. Enter the disease, or complication(s) that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Acute Myocardial Infarction Approximate Interval Between Onset and Death 1 week								
	23b. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Congestive Heart Failure Years Years								
	23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify)								
	23d. Date of delivery Month Day Year								
Medical Certification: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								
	23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown								
	24a. Was an autopsy performed? 1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No								
	25. Was case referred to medical examiner? 1 Yes 2 No 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)								
	27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined 28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 28c. Injury at Work? 1 Yes 2 No 28d. Describe how injury occurred								
	28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)								
	29a. Certifier (Check only one) 1 Certifying Physician 2 Medical Examiner : To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
	29b. Signature and title of certifier H. L. Saenger MD 29c. License number D 46561 29d. Date signed (Month, Day, Year) April, 09, 2007								
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GHAZALA BASIR 1190 MT AETNA ROAD HAGERSTOWN MD 21740								
	31. Date filed (Month, Day, Year) APR 16 2007		32. Registrar's Signature H. L. Saenger						

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 12044

1. For State Registrar

Physician /Medical Examiner

Funeral Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
 Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

1. Decedent's Name (First, Middle, Last) George Grkovic				2. Date of Death Month March Day 27 Year 2007	3. Time of Death 12:30 PM
4a. Facility Name (If not institution, give street and number) Anne Arundel Medical Center				4b. City, Town, or Location of Death Annapolis	
5. Social Security Number 519-03-7437		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 87 Yrs.	If Under 1 Year Months Days Hours Min.	8. Date of Birth (Month, Day, Year) Jan. 24, 1920
9. Birthplace (State or Foreign Country) Idaho				10c. County of Death Anne Arundel	
10a. State Maryland		10b. County Anne Arundel	10c. City, Town or Location Annapolis		
10e. Street and Number 7101 Bayfront Drive #522				10f. Zip Code 21403	10g. Citizen of What Country? U.S.A.
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: 1942-73		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 4		16b. Kind of Business/Industry Naval Officer U.S. Navy	
17. Father's Name (First, Middle, Last) Eli Grkovic			18. Mother's Name (First, Middle, Maiden Surname) Zorka Dokmanovic		
19a. Informant's Name/Relationship (Type, Print) George M. Grkovic/son			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 111 Crescent Court North Augusta, SC 29841		
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Baltimore Crematory		Date 3/30/2007	20c. Location - City or Town, State Baltimore, Maryland
21. Signature of Funeral Service Licensee Ford E. Liller		22. Name and Address of Facility John M. Taylor Funeral Home 147 Duke of Gloucester St., Annapolis, MD 21401			

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		Approximate Interval Between Onset and Death		
<p>a. CONGESTIVE HEART FAILURE Due to (or as a consequence of):</p> <p>b. _____ Due to (or as a consequence of):</p> <p>c. _____ Due to (or as a consequence of):</p> <p>d. _____</p>				
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome pf pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) _____ 9 <input type="checkbox"/> Unknown		
23d. Date of delivery Month Day Year				
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)	28b. Time of injury M	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
		28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29b. Signature and title of certifier DS MITCHELL		29c. License number D39037		29d. Date signed (Month, Day, Year) 3-28-07
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2001 Medical Parkway Annapolis, Maryland 21401				
31. Date filed (Month, Day, Year) MAR 30 2007		32. Registrar's Signature Barbara A. Spangler		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene
Certificate of Death

Reg. No. 2007 12045

1- For State Registrar

Physician /Medical Examiner

Funeral Director

To Be Completed by Funeral Director

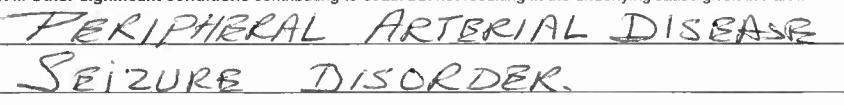
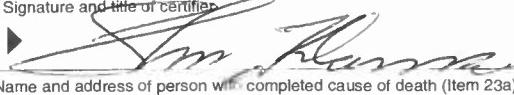
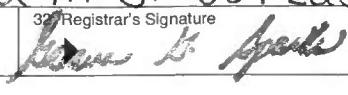
Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Division or Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last)		2. Date of Death				3. Time of Death					
SALLY M. HAYDEN		Month 04	Day 02	Year 2007	M 2008						
4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of Death			4c. County of Death						
WMHS-BRADDOCK CAMPUS		CUMBERLAND			ALLEGANY						
5. Social Security Number		6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth					
578-44-0468		1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	71 Yrs.	Months	Days	(Month, Day, Year)					
9. Birthplace (State or Foreign Country)		10d. Inside City Limits									
Cobb Island, MD		1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No									
Usual Residence of Decedent		10e. Street and Number					10f. Zip Code	10g. Citizen of What Country?			
WV		Mineral		Burlington			26710	USA			
11. Marital Status		12. Was Decedent Ever in U.S. Armed Forces?			13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)			14. Race - American Indian, Black, White, etc.			
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:			1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			Specify: White			
15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)			16b. Kind of Business/Industry						
Elementary/Secondary (0-12) 9		College (1-4or 5+) Self employed provider						child care			
17. Father's Name (First, Middle, Last)					18. Mother's Name (First, Middle, Maiden Surname)						
Thomas F. Jackson, Sr.					Sally M. Dickerson						
19a. Informant's Name/Relationship (Type, Print)			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)								
Virginia L. Moore/Daughter			Rt. 1, Box 80-A Burlington, WV 26710								
20a. Method of Disposition		20b. Place of Disposition (Name of cemetery, crematory or other place)			Date	20c. Location - City or Town, State					
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		Headsville Cemetery			April 6 2007	Keyser, WV					
21. Signature of Funeral Service Licensee		22. Name and Address of Facility									
		Smith Funeral Home									
		Rt. 2, Box 1-A Burlington, WV 26710									
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.											
Immediate Cause (Final disease or condition resulting in death)											
a. LONGEVITOUS HEART FAILURE Due to (or as a consequence of): > YEARS											
b. CORONARY ARTERY DISEASE Due to (or as a consequence of): > YEARS											
c. Due to (or as a consequence of):											
d. Due to (or as a consequence of):											
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome pf pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) _____						23d. Date of delivery Month Day Year			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.											
											
23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown											
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No									
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)									
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury	28c. Injury at Work? M 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred					
28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)								28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								29d. Date signed (Month, Day, Year)			
29b. Signature and title of certifier 		29c. License number D54004						29d. Date signed (Month, Day, Year) 4/3/7			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)											
Shiv C. Khanna M.D. 1221 East National Highway, LaVale, MD 21502											
31. Date filed (Month, Day, Year) APR 16 2007		32. Registrar's Signature 									

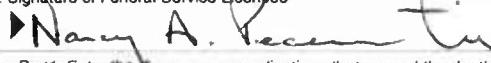
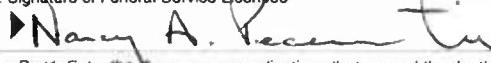
ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

1- For State Registrar		2. Date of Death Month Day Year March 27, 2007						3. Time of Death 8:10 AM		
Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Karen Jenear Harris-Zanders						4a. Facility Name (If not institution, give street and number) 1001 Spring Street #727		4b. City, Town, or Location of Death Silver Spring	4c. County of Death Montgomery
	5. Social Security Number 246-98-8162		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 49 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) October 11, 1957	9. Birthplace (State or Foreign Country) North Carolina		
Funeral Director	Usual Residence of Decedent 10a. State Maryland 10b. County Montgomery						10c. City, Town or Location Silver Spring		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
	10e. Street and Number 1001 Spring Street #727		10f. Zip Code 20910		10g. Citizen of What Country? U.S.A.					
To Be Completed by Funeral Director	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 2			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Legal Secretary			16b. Kind of Business/Industry Skadden Arps Law Firm			
17. Father's Name (First, Middle, Last) David Aughtry						18. Mother's Name (First, Middle, Maiden Surname) Maxine Harris				
19a. Informant's Name/Relationship (Type, Print) Wilton A. Zanders - Spouse						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1001 Spring St., Apt 727, Silver Spring, MD 20910				
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) 						20b. Place of Disposition (Name of cemetery, crematory or other place) Ft. Lincoln Crematory	Date 3/31/2007	20c. Location - City or Town, State Brentwood, Maryland		
21. Signature of Funeral Service Licensee 						22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Ave., Silver Spring, MD 20904				
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or art failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)						Approximate Interval Between Onset and Death			
	<p>a. METASTATIC BREAST CANCER Due to (or as a consequence of):</p> <p>b. Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. Due to (or as a consequence of):</p>									
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown						23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____			23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown				
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DDA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide						28a. Date of Injury (Month, Day, Year) March	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred	
						28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.						29c. License number D16619			29d. Date signed (Month, Day, Year) March 29, 2007	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) C. VERGARA - SOARIES						31. Date filed (Month, Day, Year) APR 02 2007			32. Registrar's Signature 	

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

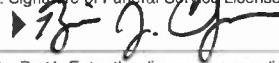
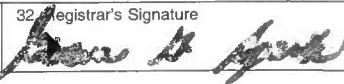
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 12047

1- For State Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Margaret Kelley Hickman					2. Date of Death Month 3 Day 28 Year 2007	3. Time of Death 11:00am								
	4a. Facility Name (If not institution, give street and number) Ginger Cove Health Center					4b. City, Town, or Location of Death Annapolis		4c. County of Death Anne Arundel							
Funeral Director	5. Social Security Number 198-01-1211	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 92 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) 6/21/1914	9. Birthplace (State or Foreign Country) PA								
To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State MD 10b. County Anne Arundel 10c. City, Town or Location Annapolis 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No														
	10e. Street and Number 2210 River Crescent Dr.			10f. Zip Code 21401			10g. Citizen of What Country? USA								
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White								
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker		16b. Kind of Business/Industry Own Home										
	17. Father's Name (First, Middle, Last) Edward Kelley				18. Mother's Name (First, Middle, Maiden Surname) Myrtle Lappe										
	19a. Informant's Name/Relationship (Type, Print) Frederic Hickman Son		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2601 Solomon's Island Rd. Edgewater, MD 21037												
Physician /Medical Examiner	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) Metro Crematory		20b. Place of Disposition (Name of cemetery, crematory or other place) Metro Crematory		Date 3/30/2007	20c. Location - City or Town, State Baltimore, MD									
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Hardesty Funeral Home, P.A. 12 Ridgely Ave. Annapolis, MD 21401												
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last														
	<table border="0"> <tr> <td>a. Hypertensive Cardiovascular Disease</td> <td>Approximate Interval Between Onset and Death years</td> </tr> <tr> <td>b. Failure to thrive</td> <td>weeks</td> </tr> <tr> <td>c. Dementia</td> <td>years</td> </tr> <tr> <td>d. _____</td> <td>_____</td> </tr> </table>							a. Hypertensive Cardiovascular Disease	Approximate Interval Between Onset and Death years	b. Failure to thrive	weeks	c. Dementia	years	d. _____	_____
a. Hypertensive Cardiovascular Disease	Approximate Interval Between Onset and Death years														
b. Failure to thrive	weeks														
c. Dementia	years														
d. _____	_____														
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown <input type="checkbox"/> Other (specify) _____					23d. Date of delivery Month Day Year							
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown							
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) _____					24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred									
			28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)									
	29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.														
	29b. Signature and title of certifier 		29c. License number D20108			29d. Date signed (Month, Day, Year) 3/29/07									
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Rakesh Arora, MD 14300 Gallant Fox Lane Bowie, MD 20715														
	31. Date filed (Month, Day, Year) MAR 30 2007		32. Registrar's Signature 												

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

10
State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene
Amend Item 27 per dr., g866, 04/16/07/db
Certificate of Death

Reg. No. 2007 12048

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) John Charles Hammer				2. Date of Death Month April Day 6 Year 2007	3. Time of Death 12:02 P M			
	4a. Facility Name (If not institution, give street and number) 8056 Geaslin Drive		4b. City, Town, or Location of Death Middletown		4c. County of Death Frederick				
Funeral Director	5. Social Security Number 220-50-5590	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 59 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days Hours Min.	8. Date of Birth (Month, Day, Year) Jan. 2, 1948	9. Birthplace (State or Foreign Country) Maryland		
To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State Maryland				10b. County Frederick			10c. City, Town or Location Woodsboro	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	10e. Street and Number 11710 Clyde Young Rd.			10f. Zip Code 21798		10g. Citizen of What Country? U.S.A.			
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: 1967-73		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) owner/operator			16b. Kind of Business/Industry construction			
	17. Father's Name (First, Middle, Last) Charles S. Hammer				18. Mother's Name (First, Middle, Maiden Surname) Aileen May Coulter				
	19a. Informant's Name/Relationship (Type, Print) Janice M. Cooney/ friend		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8056 Geaslin Dr. Middletown, MD 21769			20c. Location - City or Town, State Sykesville, MD			
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) All County Cremation		Date 4/7/2007				
	21. Signature of Funeral Service Licensee <i>Catharine O'Farrell</i>		22. Name and Address of Facility Hartzler Funeral Home 404 S. Main St. Woodsboro, MD 21798						
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) METASTATIC ADENOCARCINOMA OF RECTUM Approximate Interval Between Onset and Death 2 YEARS								
	23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown								
	23c. If yes, outcome pf pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown								
	23d. Date of delivery Month Day Year								
Medical Certification: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								
	23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown								
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> friend's home						
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred			
			28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29c. License number D 31761						
	29b. Signature and title of certifier <i>Brian M. O'Connor, MD</i>		29d. Date signed (Month, Day, Year) 4/7/2007						
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BRIAN M. O'CONNOR, MD 501 W. SEVENTH ST., FREDERICK, MD 21701								
State Registrar	31. Date filed (Month, Day, Year) APR 16 2007		32. Registrar's Signature <i>Leanne B. Foster</i>						

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

#27
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 12049

amend line 4a per phy
aaco hltth dept 4/3/07 dlw
1- State Registrar

Physician /Medical Examiner		1. Decedent's Name (First, Middle, Last) Muriel K. Jenkins						2. Date of Death Month 3 Day 22 Year 2007	3. Time of Death 3:35 p M
Funeral Director		4a. Facility Name (If not institution, give street and number) 8402 Terry Lee Way			4b. City, Town, or Location of Death Severn			4c. County of Death Anne Arundel	
To Be Completed by Funeral Director		5. Social Security Number 101-20-8579	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 75 Yrs.	If Under 1 Year Months 0 Days 0	If Under 24 Hrs. Hours 0 Min. 0	8. Date of Birth (Month, Day, Year) 6/12/1931	9. Birthplace (State or Foreign Country) USA	
To Be Completed by Physician/Medical Examiner		10a. State MD		10b. County Anne Arundel	10c. City, Town or Location Severn				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
To Be Completed by Physician/Medical Examiner		10e. Street and Number 8402 Terry Lee Way			10f. Zip Code 21114			10g. Citizen of What Country? USA	
To Be Completed by Physician/Medical Examiner		11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: 34	13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: Black	
To Be Completed by Physician/Medical Examiner		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Administrative Assistant	16b. Kind of Business/Industry NYPD				
To Be Completed by Physician/Medical Examiner		17. Father's Name (First, Middle, Last) Donald Anderson			18. Mother's Name (First, Middle, Maiden Surname) Millicent Hamblin				
To Be Completed by Physician/Medical Examiner		19a. Informant's Name/Relationship (Type, Print) Rhonda D. Marshall (Daughter)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1019 Wheatfield Dr. Millersville, MD 21108					
To Be Completed by Physician/Medical Examiner		20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) ► 34		20b. Place of Disposition (Name of cemetery, crematory or other place) Long Island National	Date 03/30/2007	20c. Location - City or Town, State Long Island, NY			
To Be Completed by Physician/Medical Examiner		21. Signature of Funeral Service Licensee ► 34		22. Name and Address of Facility Hardesty Funeral Home 851 Annapolis Rd, Gambrills, MD 21054					
To Be Completed by Physician/Medical Examiner		23a. Part I. Enter the disease, complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last						Approximate Interval Between Onset and Death	
To Be Completed by Physician/Medical Examiner		<p>a. Due to (or as a consequence of): Endometrial Cancer</p> <p>b. Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. Due to (or as a consequence of):</p>							
To Be Completed by Physician/Medical Examiner		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome pf pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown			23d. Date of delivery Month 0 Day 0 Year 0		
To Be Completed by Physician/Medical Examiner		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
To Be Completed by Physician/Medical Examiner								24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No
To Be Completed by Physician/Medical Examiner		25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
To Be Completed by Physician/Medical Examiner		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred		
To Be Completed by Physician/Medical Examiner				28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)		
To Be Completed by Physician/Medical Examiner		29a. Certifier <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier ► 34		29c. License number D29142			29d. Date signed (Month, Day, Year) March 26, 2007		
To Be Completed by Physician/Medical Examiner		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Charles Boice 110 Irving St. NW Washington DC 20010							
State Registrar		31. Date filed (Month, Day, Year) MAR 3 0 2007		32. Registrars Signature 					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2007 12050

Reg. No.

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) LeRoy Jensen							2. Date of Death Month Day Year April 1, 2007	3. Time of Death 1:00P M			
	4a. Facility Name (If not institution, give street and number) 2510 Rockwood Road			4b. City, Town, or Location of Death Accokeek			4c. County of Death Prince Georges					
Funeral Director	5. Social Security Number 218-30-4360		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 86 Yrs.	If Under 1 Year Months 0	If Under 24 Hrs. Days 0	Hours 0	Min. 0	8. Date of Birth (Month, Day, Year) February 9, 1921	9. Birthplace (State or Foreign Country) Iowa		
	Usual Residence of Decedent 10a. State MD 10b. County Prince Georges 10c. City, Town or Location Accokeek									10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
To Be Completed by Funeral Director	10e. Street and Number 2510 Rockwood Road				10f. Zip Code 20607			10g. Citizen of What Country? USA				
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: 5+		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White				
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Teacher		16b. Kind of Business/Industry Education							
Physician /Medical Examiner	17. Father's Name (First, Middle, Last) Jens Christian Jensen				18. Mother's Name (First, Middle, Maiden Surname) Margrethe Mumgaard							
	19a. Informant's Name/Relationship (Type, Print) Nancy Tyree/Daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13525 Furbush Road, Newburg, MD 20664							
To Be Completed by Physician/Medical Examiner	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Brinsfield-Echols		Date 4/3/07	20c. Location - City or Town, State Charlotte Hall, Maryland						
	21. Signature of Funeral Service Licensee ►Loyd C. Echols		M00945		22. Name and Address of Facility AREHART-ECHOLS FUNERAL HOME, P.A 211 St. Mary's Ave. La Plata, MD 20646							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last										Approximate Interval Between Onset and Death		
<p>a. CHRONIC RESPIRATORY FAILURE Due to (or as a consequence of):</p> <p>b. CHRONIC OBSTRUCTIVE LUNG DISEASE Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. </p>												
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown						23d. Date of delivery Month Day Year				
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CORONARY ARTERY DISEASE PARKINSON'S DISEASE										23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		
										24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
										24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)										
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred						
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician : To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner : On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29c. License number 012906										
29b. Signature and title of certifier ► Louis Kaufman, M.D.		29d. Date signed (Month, Day, Year) 4/2/07										
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Louis Kaufman, M.D. 12070 Old Line Center, Waldorf, MD 20601												
31. Date filed (Month, Day, Year) APR 03 2007		32. Registrar's Signature ▶ Steven B. Smith										

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit once.

Important: If item 21 is marked other than "natural", or items 23a or 28e show any injury or other traumatic event, the Medical Examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2007 12051
Reg. No.

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Grace L. Knight							2. Date of Death Month Day Year April 07 2007		3. Time of Death 5:15 P.M.								
	4a. Facility Name (If not institution, give street and number) LORIEN @ RIVERSIDE			4b. City, Town, or Location of Death BELKAMP			4c. County of Death HARFORD											
Funeral Director	5. Social Security Number 217-12-0792	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 88 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month Day Year) Mar. 2, 1919	9. Birthplace (State or Foreign Country) Maryland											
Usual Residence of Decedent										10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
To Be Completed by Funeral Director	10a. State MD			10b. County Harford	10c. City, Town or Location Havre de Grace													
	10e. Street and Number 3701 Level Village Road			10f. Zip Code 21078			10g. Citizen of What Country? U.S.A.											
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: 1945-1948		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: White			14. Race - American Indian, Black, White, etc. Specify: White										
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker			16b. Kind of Business/Industry In Home											
	17. Father's Name (First, Middle, Last) Thomas McGreevy				18. Mother's Name (First, Middle, Maiden Surname) Mary Helena Crystal													
	19a. Informant's Name/Relationship (Type, Print) Jane Seiler (Daughter)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 765 Everist Dr. Aberdeen, MD 21001													
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) Bel Air Mem. Gdns.				20b. Place of Disposition (Name of cemetery, crematory or other place) Tanning-Cargo Funeral Home P.A.		Date 4/13/07	20c. Location - City or Town, State Bel Air, Maryland										
	21. Signature of Funeral Service Licensee Kirsten Amy Anglesbury				22. Name and Address of Facility Aberdeen, Maryland 21001-3399													
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Myocardial infarction									Approximate Interval Between Onset and Death								
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Chronic hypertension																	
	a. Due to (or as a consequence of): Chronic hypertension																	
	b. Due to (or as a consequence of): Myocardial infarction																	
	c. Due to (or as a consequence of): Myocardial infarction																	
	d. Due to (or as a consequence of): Myocardial infarction																	
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown		3. Ectopic pregnancy <input type="checkbox"/> Other (Specify) Unknown		23d. Date of delivery Month Day Year											
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Diabetes mellitus																	
	23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown																	
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No												
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No									26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) At home								
	27. Manner of Death Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide Pending investigation <input type="checkbox"/> Could not be determined									28a. Date of Injury (Month, Day Year) APR 16 2007		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No No		28d. Describe how injury occurred At home		
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) At home									28f. Location (Street and Number or Rural Route Number, City or Town, State) 319 S. UNION AVE HDE MD 2078								
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. H. Sung Kim M.D.									29c. License number D46412		29d. Date signed (Month, Day, Year) 4/16/07						
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) H. Sung Kim 319 S. UNION AVE HDE MD 2078																	
	31. Date filed (Month, Day, Year) APR 16 2007				32. Registrar's Signature Jane Seiler													

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit slip.

Medical Certification: To Be Completed by Physician/Medical Examiner

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or if items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 12052

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last)							2. Date of Death Month Day Year			3. Time of Death	
	ADA MAE LAIRD							April 9, 2007			12:10 P M	
Funeral Director	4a. Facility Name (If not institution, give street and number)							4b. City, Town, or Location of Death			4c. County of Death	
	Alice Byrd Tawes Nursing Home							Crisfield			Somerset	
5. Social Security Number		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 82 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) June 17, 1924	9. Birthplace (State or Foreign Country) Maryland					
Usual Residence of Decedent		10a. State Maryland		10b. County Somerset		10c. City, Town or Location Crisfield			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
10e. Street and Number 26312 Byrd Road		10f. Zip Code 21817		10g. Citizen of What Country? USA								
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 9		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+)		16b. Kind of Business/Industry Clerk								
17. Father's Name (First, Middle, Last) Lucious Lewis		18. Mother's Name (First, Middle, Maiden Surname) Mamie Pestridge										
19a. Informant's Name/Relationship (Type, Print) John W. Laird, Jr. (Husband)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 26312 Byrd Road - Crisfield, Maryland 21817										
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Sunnyridge Memorial Park		Date April 12, 2007			20c. Location - City or Town, State Crisfield, Maryland					
21. Signature of Funeral Service Licensee ► Mary Beth Bradshaw-Pruitt		22. Name and Address of Facility Bradshaw & Sons Funeral Home 306 W. Main St. - Crisfield, MD 21817										
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		23b. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year			Approximate Interval Between Onset and Death By years					
23c. Due to (or as a consequence of): a. <i>End stage Alzheimer's Disease</i>		23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown										
23f. Due to (or as a consequence of): b. <i></i>		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
23g. Due to (or as a consequence of): c. <i></i>												
23h. Due to (or as a consequence of): d. <i></i>												
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown								
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)										
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury	28c. Injury at Work? M	28d. Describe how injury occurred						
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.												
29b. Signature and title of certifier Michael Atkins MD		29c. License number D-39813		29d. Date signed (Month, Day, Year) 4/16/2007								
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Michael Atkins MD 201 16th Street, Crisfield MD 21817		31. Date filed (Month, Day, Year) APR 16 2007		32. Registrar's Signature Leanne B. Sparta								

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Physician/ Medical Examiner		1. For State Registrar		2. Date of Death Month Day Year March 27, 2007		3. Time of Death 1113 hrs	
Funeral Director		4a. Facility Name (if not institution, give street and number) Suburban Hospital		4b. City, Town, or Location of Death Bethesda		4c. County of Death Montgomery	
To Be Completed by Funeral Director		5. Social Security Number 616-66-0266		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 17 Yrs.	
To Be Completed by Funeral Director		8. If Under 1 Year Months Days Hours Min.		9. Date of Birth (MM/DD/YYYY) May 3, 1989		10. Birthplace (State or Foreign Country) Sweden	
To Be Completed by Funeral Director		10a. Usual Residence of Decedent MD Montgomery		10b. City, Town or Location Rockville		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
To Be Completed by Funeral Director		10e. Street and Number 10618 Sawdust Circle		10f. Zip Code 20850		10g. Citizen of What Country? Sweden	
To Be Completed by Physician/Medical Examiner		11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
To Be Completed by Physician/Medical Examiner		14. Race - American Indian, Black, White, etc. Specify: Asian		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Student	
To Be Completed by Physician/Medical Examiner		16b. Kind of Business/Industry Education		17. Father's Name (First, Middle, Last) Tie-Qiang Li		18. Mother's Name (First, Middle, Maiden Surname) Hongjie Janet Li	
To Be Completed by Physician/Medical Examiner		19a. Informant's Name/Relationship (Type, Print) Tie-Qiang Li / Father		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10618 Sawdust Circle, Rockville, MD 20850		20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other Specify: Metropolitan Crematory	
To Be Completed by Physician/Medical Examiner		20b. Place of Disposition (Name of cemetery, crematory or other place) Metropolitan Crematory		Date March 31 2007		20c. Location - City or Town, State Alexandria, Virginia	
To Be Completed by Physician/Medical Examiner		21. Signature of Funeral Service Licensee Tracy A. Lewis		22. Name and Address of Facility DeVol Funeral Home, 10 East Deer Park Drive, Gaithersburg, MD 20877		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Multiple Injuries Due to (or as a consequence of):	
To Be Completed by Physician/Medical Examiner		b. Due to (or as a consequence of):		c. Due to (or as a consequence of):		d. Due to (or as a consequence of):	
To Be Completed by Physician/Medical Examiner		<input type="checkbox"/> UNPENDED <input type="checkbox"/> AMENDED		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown		Approximate Interval Between Onset and Death	
To Be Completed by Physician/Medical Examiner		23d. Date of delivery Month Day Year		23e. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown		23f. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
To Be Completed by Physician/Medical Examiner		24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner		Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA		26. Place of Death (Check only one) Other 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other		27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input checked="" type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Homicide	
To Be Completed by Physician/Medical Examiner		28a. Date of Injury (Month, Day, Year) Mar 27, 2007		28b. Time of Injury 1010 hrs		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Local Street		28f. Describe how injury occurred Subject bicyclist struck by vehicle		28f. Location (Street and Number or Rural Route Number, City or Town, State) River Road & Travilah Road, Potomac, MD	
To Be Completed by Physician/Medical Examiner		29a. Certifier 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated		29b. Signature and title of certifier Melissa Brassell, MD		29c. License number O.C.M.E.	
To Be Completed by Physician/Medical Examiner		29d. Date signed (Month, Day, Year) March 28, 2007		30. Name and address of person who completed cause of death (Item 23a) Melissa Brassell, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201		31. Date filed (Month, Day, Year) APR 02 2007	
State Registrar		32. Registrar's Signature Leanne L. Gandy		33. Original			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2007 12051
Reg. No.1- For
State
Registrar

1. Decedent's Name (First, Middle, Last)

William Ralph Lenz Sr.

2. Date of Death

Month Day Year

March 28, 2007

3. Time of Death

11:30 P M

Physician
/Medical
Examiner

4a. Facility Name (If not institution, give street and number)

Wilson Health Care Center

4b. City, Town, or Location of Death

Gaithersburg

4c. County of Death

Montgomery

Funeral
Director

5. Social Security Number

162-18-9697

6. Sex

 M

7. Age (In yrs. last birthday)

88

Yrs.

If Under 1 Year

If Under 24 Hrs.

8. Date of Birth

(Month, Day, Year)

9. Birthplace (State or Foreign Country)

PA

Months

Days

Hours

Min.

Oct 3, 1918

9. Birthplace (State or Foreign Country)

10a. Usual Residence of Decedent

State

MD

10b. County

Montgomery

10c. City, Town or Location

Gaithersburg

10d. Inside City Limits

 Yes No

10e. Street and Number

301 Russell Avenue #325

10f. Zip Code

20877

10g. Citizen of What Country?

United States

11. Marital Status

1 Never Married 2 Married
3 Widowed 4 Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give Year or Dates: WW II

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 Yes 2 No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Plate Printer

16b. Kind of Business/Industry

Government

17. Father's Name (First, Middle, Last)

Charles J. Lenz

18. Mother's Name (First, Middle, Maiden Surname)

Minnie Wyland

19a. Informant's Name/Relationship (Type, Print)

Wilma R. Glass (Daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

403 E. Charlotte Street, Sterling, VA 20164

20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Gate of Heaven Cemetery

Date

Apr 2

20c. Location - City or Town, State

Silver Spring, MD

21. Signature of Funeral Service Licensee

Tracy A. Stave

22. Name and Address of Facility

Devol Funeral Home

10 East Deer Park Drive, Gaithersburg, MD 20877

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Acute myocardial infarction Minutes

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

{

a. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No
9 Unknown23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 3 Ectopic pregnancy
4 Pregnant at time of death 5 Other (Specify)
9 Unknown23d. Date of delivery
Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Diabetes type II, Hypothyroidism,
Hyperlipidemia, Osteoarthritis,
Demencia.

23e. Did tobacco use contribute to the cause of death?

1 Yes 2 No 3 Probably 4 Unknown

25. Was case referred to medical examiner?

1 Yes 2 No

27. Manner of Death

1 Natural 5 Pending investigation
2 Accident 6 Could not be determined
3 Suicide 4 HomicideHospital: 1 Inpatient 2 ER/Outpatient 3 DOAOther: 4 Nursing Home 5 Residence 6 Other (Specify)

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 Yes 2 No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

H. Robert Birschbahl MD

29c. License number

004165

29d. Date signed (Month, Day, Year)

March 29, 2007

30. Name and address of person who completed cause of death (Item 2a) Type, Print)

H. ROBERT BIRSCHEBHALD MD

301 RUSSELL AVENUE
GAITHERSBURG, MD 20877

31. Date filed (Month, Day, Year)

APR 02 2007

32. Registrar's Signature

Bruce B. Birschbahl

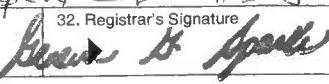
Please Type or Print In Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007-12055

1- For State Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Carl Martin Luther							2. Date of Death Month Day Year April 1 2007	3. Time of Death 1:35 a M				
	4a. Facility Name (If not institution, give street and number) Harford Memorial Hospital			4b. City, Town, or Location of Death Havre de Grace			4c. County of Death Harford						
Funeral Director	5. Social Security Number 213-68-1126		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 50 Yrs.		If Under 1 Year Months Days Hours Min. 0 0 0 0		8. Date of Birth (Month, Day, Year) Jan. 15, 1957		9. Birthplace (State or Foreign Country) Maryland		
	Usual Residence of Decedent 10a. State Maryland 10b. County Cecil 10c. City, Town or Location Port Deposit 10e. Street and Number 392 Rock Run Road 10f. Zip Code 21904 10g. Citizen of What Country? U.S.A.												
To Be Completed by Funeral Director	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White				
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Twelve Years		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Clerk			16b. Kind of Business/Industry Acme Market							
17. Father's Name (First, Middle, Last) Kenneth Martin Luther						18. Mother's Name (First, Middle, Maiden Surname) Rebecca Myrle Bullock							
19a. Informant's Name/Relationship (Type, Print) Renee' S. Luther (wife)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 392 Rock Run Road, Port Deposit, Maryland 21904									
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) R.A. Ferris & Co., Inc.			Date 04/03/07	20c. Location - City or Town, State West Chester, Pennsylvania					
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Lee A. Patterson & Son Funeral Home, P.A. Perryville, Maryland 21903-0766									
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last													
a. Hepatocellular Carcinoma Approximate Interval Between Onset and Death Months Due to (or as a consequence of): b. Cirrhosis Years Due to (or as a consequence of): c. HCV hepatitis Years Due to (or as a consequence of): d. Renal failure Weeks													
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome pf pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify)							23d. Date of delivery Month Day Year				
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.													
23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown													
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)											
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year) March 1 2007		28b. Time of Injury M PM		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred					
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) At home										28f. Location (Street and Number or Rural Route Number, City or Town, State) Carroll Luther, P.O. Box 68760, Perryville, MD 21903-0766	
29b. Signature and title of certifier 		29c. License number D0047827										29d. Date signed (Month, Day, Year) 4/21/07	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Peter Park 520 Upper Chesapeake Dr #303 Bell Air MD 21014													
31. Date filed (Month, Day, Year) APR 3 2007		32. Registrar's Signature 											

Baltimore, Maryland 21215-0036

4/11/07

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State Registrar

Division or Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 12056

1- For State Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Robert Long			2. Date of Death Month Day Year MARCH 31 2007		3. Time of Death 1554 P M			
	4a. Facility Name (If not institution, give street and number) The Johns Hopkins Hospital			4b. City, Town, or Location of Death Baltimore City		4c. County of Death			
Funeral Director	5. Social Security Number 217-64-1753	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 47 Yrs.	If Under 1 Year Months Days Hours Min.	8. Date of Birth (Month, Day, Year) June 23, 1959		9. Birthplace (State or Foreign Country) Maryland		
	Usual Residence of Decedent 10a. State Maryland 10b. County Harford			10c. City, Town or Location Bel Air			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
To Be Completed by Funeral Director	10e. Street and Number 224A Timber Trail			10f. Zip Code 21014		10g. Citizen of What Country? U.S.A.			
Physician /Medical Examiner	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: 1980-82		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White			
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Twelve Years		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Laborer		16b. Kind of Business/Industry Ropewalk Bel Air, Maryland				
	17. Father's Name (First, Middle, Last) Thomas Patrick Long			18. Mother's Name (First, Middle, Maiden Surname) Angela Kathryn Vizzini					
	19a. Informant's Name/Relationship (Type, Print) Michael P. Long (Brother)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1303 Lavender Lane, Belcamp, Maryland 21017						
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) Harford Memorial Gardens		20b. Place of Disposition (Name of cemetery, crematory or other place) Harford Memorial Gardens		Date 04/04/07	20c. Location - City or Town, State Aberdeen, Maryland			
	21. Signature of Funeral Service Licensee Thomas H. Patterson, Sr.		22. Name and Address of Facility Lee A. Patterson & Son Funeral Home, P.A. Perryville, Maryland 21903-0766						
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		Approximate Interval Between Onset and Death 5 years 1 week						
	a. End Stage Liver Disease Due to (or as a consequence of): Acute Renal Failure								
	b. Due to (or as a consequence of): Acute Renal Failure								
	c. Due to (or as a consequence of):								
	d. Due to (or as a consequence of):								
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome pf pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year				
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								
	23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown								
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year) M		28b. Time of Injury M <input type="checkbox"/> Yes <input type="checkbox"/> No	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No			28d. Describe how injury occurred
			28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) At home					28f. Location (Street and Number or Rural Route Number, City or Town, State) 21287	
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29c. License number RES-000						29d. Date signed (Month, Day, Year) March 31, 2007
	29b. Signature and title of certifier Ben Shoemaker, MD								
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ben Shoemaker, MD 600 North Wolfe Street Baltimore Maryland								
State Registrar	31. Date filed (Month, Day, Year) APR 3 2007		32. Registrar's Signature Ben Shoemaker						

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

31 VA

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 12057

1- For State Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) RAYMOND E. LLOYD JR							2. Date of Death Month 03 Day 29 Year 2007	3. Time of Death 0140AM		
	4a. Facility Name (If not institution, give street and number) Peninsula Regional Med. Center			4b. City, Town, or Location of Death Salisbury, MD			4c. County of Death Wicomico				
Funeral Director	5. Social Security Number 221-18-5158	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 76 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days Hours Min.	8. Date of Birth (Month, Day, Year) 11-03-30	9. Birthplace (State or Foreign Country) Delaware				
To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State Delaware 10b. County Sussex			10c. City, Town or Location Seaford			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
	10e. Street and Number 25175 Hickory Lane			10f. Zip Code 19973			10g. Citizen of What Country? US				
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: 1950-1954		13. Was Decedent of Hispanic Origin? (Specify Yes or No) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: white			14. Race - American Indian, Black, White, etc. Specify: white				
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Teacher		16b. Kind of Business/Industry College						
	17. Father's Name (First, Middle, Last) Raymond E. Lloyd Sr.			18. Mother's Name (First, Middle, Maiden Surname) Margaret Morgan							
	19a. Informant's Name/Relationship (Type, Print) Madeline Lloyd - wife			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 25175 Hickory Rd, Seaford, DE 19973							
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) Capitol Crematory			20b. Place of Disposition (Name of cemetery, crematory or other place) Capitol Crematory			Date 3/30/2007	20c. Location - City or Town, State Dover, DE			
	21. Signature of Funeral Service Licensee John A. Cranston			22. Name and Address of Facility Cranston Funeral Home P O Box 967, Seaford, DE 19973							
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. pulmonary edema Due to (or as a consequence of): b. cardiomyopathy Due to (or as a consequence of): c. coronary artery disease Due to (or as a consequence of): d. _____								Approximate Interval Between Onset and Death hours days years		
	23b. If female: Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown			23c. If yes, outcome pf pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) _____			23d. Date of delivery Month Day Year				
Medical Certification: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Acute renal failure								23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) _____			23f. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide			28a. Date of Injury (Month, Day Year) M			28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred		
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.			28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)				
	29b. Signature and title of certifier Jeff E. Elkhorn			29c. License number D36783 ms			29d. Date signed (Month, Day, Year) 03, 29, 07				
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jeff E. Elkhorn 100 E Carroll St. Salisbury, MD 21801										
State Registrar	31. Date filed (Month, Day, Year) MAR 30 2007		32. Registrar's Signature James B. Apelt								

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
 Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

SMB
IVA

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 12058

1 - For State Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Thomas Edward Miss							2. Date of Death Month Day Year April 6, 2007	3. Time of Death M 3:15 P M	
	4a. Facility Name (If not institution, give street and number) 1592 Abbey Court			4b. City, Town, or Location of Death Frederick			4c. County of Death Frederick			
Funeral Director	5. Social Security Number 216-30-3794	6. Sex 1 X M 2 □ F	7. Age (In yrs. last birthday) 72 Yrs.	If Under 1 Year Months 72	If Under 24 Hrs. Days 0	Hours 0	Min. 0	8. Date of Birth (Month, Day, Year) May 15, 1934	9. Birthplace (State or Foreign Country) Maryland	
	Usual Residence of Decedent 10a. State Maryland								10b. County Frederick	10c. City, Town or Location Frederick
To Be Completed by Funeral Director	10e. Street and Number 1592 Abbey Court			10f. Zip Code 21701			10g. Citizen of What Country? USA			
	11. Marital Status 1 □ Never Married 2 X Married 3 □ Widowed 4 □ Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 X No If Yes, Give Year or Dates: 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (1-4 or 5+) Stone Mason			13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 □ Yes 2 X No Specify: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Masonry Construction			14. Race - American Indian, Black, White, etc. White
17. Father's Name (First, Middle, Last) William Edward Miss					18. Mother's Name (First, Middle, Maiden Surname) Laura Gertrude Lininger					
19a. Informant's Name/Relationship (Type, Print) Dolores Miss, wife					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1592 Abbey Court, Frederick, Maryland 21701					
20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Mt. Olivet Cemetery			Date 4/12/2007	20c. Location - City or Town, State Frederick, Maryland			
21. Signature on Funeral Service License Ryan M. Berger					22. Name and Address of Facility Keeney and Basford Funeral Home M00999 106 East Church Street, Frederick, MD 21701					
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last									Approximate Interval Between Onset and Death 13 years
	<p>a. METASTATIC SQUAMOUS CELL CANCER OF THE SUFRA GLOWS Due to (or as a consequence of):</p> <p>b. Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. Due to (or as a consequence of):</p>									
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown			23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify)			23d. Date of delivery Month Day Year				
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									23e. Did tobacco use contribute to the cause of death? X Yes 2 □ No 3 □ Probably 4 □ Unknown	
25. Was case referred to medical examiner? 1 □ Yes 2 X No			26. Place of Death (Check only one) Hospital: 1 □ Inpatient 2 □ ER/Outpatient 3 □ DOA Other: 4 □ Nursing Home 5 X Residence 6 □ Other (Specify)							
27. Manner of Death 1 X Natural 5 □ Pending investigation 2 □ Accident 6 □ Could not be determined 3 □ Suicide 4 □ Homicide			28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	28c. Injury at Work? 1 □ Yes 2 □ No	28d. Describe how injury occurred			
			28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 □ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.			29b. Signature and title of certifier Brian M. O'Connor							
29c. License number D31761			29d. Date signed (Month, Day, Year) April 9, 2007							
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Brian M. O'Connor, MD, 501 West Seventh Street, Frederick, Maryland 21701										
31. Date filed (Month, Day, Year) APR 16 2007			32. Registrar's Signature Leanne A. Apke							

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760, Frederick, Maryland 21704

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 12059

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) FAITH L. McDORMAN							2. Date of Death Month April Day 8 Year 2007	3. Time of Death 2:40 A M	
	4a. Facility Name (If not institution, give street and number) Harford Memorial Hospital			4b. City, Town, or Location of Death Havre de Grace			4c. County of Death Harford			
Funeral Director	5. Social Security Number 214-36-8928	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 68 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) 6/9/1938	9. Birthplace (State or Foreign Country) Maryland			
To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State MD 10b. County Harford 10c. City, Town or Location Whiteford 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No									
	10e. Street and Number 2168 Line Bridge Road			10f. Zip Code 21160			10g. Citizen of What Country? USA			
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: Specify: White			14. Race - American Indian, Black, White, etc.		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Clerical			16b. Kind of Business/Industry Civil Service			
	17. Father's Name (First, Middle, Last) Ernest D. Henry, Sr.				18. Mother's Name (First, Middle, Maiden Surname) Nellie Mae Hopkins					
	19a. Informant's Name/Relationship (Type, Print) Larry McDorman/Son			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2168 Line Bridge Road, Whiteford, MD 21160						
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) Evans Eagle Crematory			20b. Place of Disposition (Name of cemetery, crematory or other place) Evans Eagle Crematory			Date 4/10/2007	20c. Location - City or Town, State Leola, PA		
	21. Signature of Funeral Service Licensee 									
	22. Name and Address of Facility Harkins Funeral Home, Inc., Delta, PA 17314									
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Resp Failure COPD Cardiac Myopathy								Approximate Interval Between Onset and Death	
	23b. Part II. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last									
	23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fatal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown									23d. Date of delivery Month Day Year
	23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown									
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No									24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No									26. Place of Death (Check only one) <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide									28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No 28d. Describe how injury occurred
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)									28f. Location (Street and Number or Rural Route Number, City or Town, State)
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
	29b. Signature and title of certifier 									29c. License number D0062903
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ANAS ATRASH MD 319 Union Ave Havre De Grace MD 21078									29d. Date signed (Month, Day, Year) 04/08/07
State Registrar	31. Date filed (Month, Day, Year) APR 16 2007			32. Registrar's Signature 						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2007 12060

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last)							2. Date of Death Month Day Year	3. Time of Death
	Lilly May Maher							April 8 2007	9:10 AM
Funeral Director	4a. Facility Name (If not institution, give street and number)			4b. City, Town, or Location of Death			4c. County of Death		
	Harford Memorial Hospital			Havre de Grace			Harford		
5. Social Security Number		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 75 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	Hours	Min.	8. Date of Birth (Month, Day, Year) Feb. 10, 1932	9. Birthplace (State or Foreign Country) Maryland
Usual Residence of Decedent									
10a. State MD	10b. County Harford	10c. City, Town or Location Havre de Grace						10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number 100 Revolution St. Apt. 308				10f. Zip Code 21078			10g. Citizen of What Country? U.S.A		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 6				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker			16b. Kind of Business/Industry Homemaker		
17. Father's Name (First, Middle, Last) John Cora					18. Mother's Name (First, Middle, Maiden Surname) Dora Parsley				
19a. Informant's Name/Relationship (Type, Print) Kenneth Maher (Son)									
20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)					20b. Place of Disposition (Name of cemetery, crematory or other place) R.A. Ferris & Co.			Date 4/12/2007	20c. Location - City or Town, State West Chester, PA
21. Signature of Funeral Service Licensee Yaya C. Zellman									
22. Name and Address of Facility Mitchell-Smith Funeral Home, P.A. 123 S. Washington St. Havre de Grace, MD 21078									
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Resp Failure									
Approximate Interval Between Onset and Death									
Subsequently list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Cardiac Arrest									
23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown									
23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown									
23d. Date of delivery Month Day Year									
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									
23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown									
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No									
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No									
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No									
26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)									
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide									
28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No									
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)									
28f. Location (Street and Number or Rural Route Number, City or Town, State)									
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
29b. Signature and title of certifier ANAS ATRASII, MD									
29c. License number D0662903									
29d. Date signed (Month, Day, Year) 04/08/07									
30. Name of person who completed cause of death (Item 23a) (Type, Print) ANAS ATRASII, MD 319 S Union Ave Havre De Grace MD 21078									
31. Date filed (Month, Day, Year) APRIL 6 2007									
32. Registrar's Signature Lily May Maher									

10am

A-08-07

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28d show any injury or other traumatic event, Medical Examiner must be notified.

40am

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2007 1206

1- For State Registrar

Physician/Medical Examiner	1. Decedent's Name (First, Middle, Last) Andrew Joseph McGowan					2. Date of Death Month April Day 6 , Year 2007			3. Time of Death 1557 hrs		
Funeral Director	4a. Facility Name (if not institution, give street and number) 13003 Country Ridge			4b. City, Town, or Location of Death Germantown			4c. County of Death Montgomery				
	5. Social Security Number 220-56-7253	6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) 57 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days		8. Date of Birth (MM/DD/YYYY) Jan. 14, 1950	9. Birthplace (State or Foreign Country) Ohio			
						Hours Min.					
To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State Maryland 10b. County Montgomery 10c. City, Town or Location Silver Spring								10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
	10e. Street and Number 3310 N. Leisure World Blvd., #1006					10f. Zip Code 20906			10g. Citizen of What Country? USA		
Physician/Medical Examiner	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No specify			14. Race - American Indian, Black, White, etc. Specify: White			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Stone Mason			16b. Kind of Business/Industry Carpenter				
	17. Father's Name (First, Middle, Last) William A. McGowan					18. Mother's Name (First, Middle, Maiden Surname) Manuela Marie Corey					
	19a. Informant's Name/Relationship (Type, Print) William A. McGowan/Father					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3310 N. Leisure World Blvd., #1006, Silver Spring, MD 20906					
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other Specify	20b. Place of Disposition (Name of cemetery, crematory or other place) Gate of Heaven Cemetery			Date April 12, 2007	20c. Location - City or Town, State Silver Spring, Maryland					
	21. Signature of Funeral Service Licensee Andrew J. Cole					22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd., W., Silver Spring, MD 20901					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Pulmonary embolus Due to (or as a consequence of): b. Deep vein thromboses Due to (or as a consequence of): c. Due to (or as a consequence of): d.										
	Approximate Interval Between Onset and Death										
	<input checked="" type="checkbox"/> UNPENDED	<input type="checkbox"/> AMENDED #23a-b, PII, 27, per ME, g868 6/11/07 TT									
	IF FEMALE:		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year					
	23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown										
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Status post brain tumor										
	23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown										
	24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No						
	25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		26 Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other: Scene								
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year) (Specify)		28b. Time of Injury 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			28d. Describe how injury occurred	
										28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State) (Specify)
	29a. Certifier 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
	29b. Signature and title of certifier J. Titus MD.		29c. License number O.C.M.E.			29d. Date signed (Month, Day, Year) April 7, 2007					
	30. Name and address of person who completed cause of death (Item 23a) Jack Titus MD. Deputy Chief Medical Examiner 111 Penn Street, Baltimore, MD 21201										
	31. Date filed (Month, Day, Year) APR 11 2007		32. Registrar's Signature James B. Cole								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 12062

1 - For
State
RegistrarPhysician
/Medical
ExaminerFuneral
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 21 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at all times.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit slip.

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month APRIL Day 1, Year 2007				3. Time of Death 2:25 P M	
PEARL SEDESSA HAMN MARBURY		4b. City, Town, or Location of Death LA PLATA				4c. County of Death CHARLES	
4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of Death LA PLATA				4c. County of Death CHARLES	
CHARLES COUNTY NURSING & REHABILITATION CENTER							
5. Social Security Number 213-38-2259		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 80 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days Hours Min.	8. Date of Birth (Month Day Year) JANUARY 1, 1927	
Usual Residence of Decedent 10a. State MARYLAND		10b. County CHARLES				9. Birthplace (State or Foreign Country) VIRGINIA	
10e. Street and Number 3250 LIVINGSTON ROAD		10f. Zip Code 20640				10g. Citizen of What Country? UNITED STATES	
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: BLACK	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12TH GRADE		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+)		16b. Kind of Business/Industry HOUSEWIFE		HOME MAKER	
17. Father's Name (First, Middle, Last) FREDERICK HAMILTON HAMN		18. Mother's Name (First, Middle, Maiden Surname) ANNIE MORTON HAMN					
19a. Informant's Name/Relationship (Type, Print) REGINALD A. MARBURY / SON		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4205 MARBURY FREELAND PLACE, INDIAN HEAD, MARYLAND				20640	
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) MARYLAND VETERANS CEMETERY		Date APRIL 5, 2007	20c. Location - City or Town, State CHELTENHAM, MARYLAND		
21. Signature of Funeral Service Licensee LYDIA C. THORNTON JOHNSON MO0583		22. Name and Address of Facility THORNTON FUNERAL HOME, P.A. 3439 LIVINGSTON ROAD, INDIAN HEAD, MARYLAND 20640					
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
Immediate Cause (Final disease or condition resulting in death)		a. Congestive Heart Failure Due to (as a consequence of):					Approximate Interval Between Onset and Death
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		b. _____ Due to (as a consequence of):					
		c. _____ Due to (as a consequence of):					
		d. _____					
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown				23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
29b. Signature and title of certifier 		29c. License number 00052919				29d. Date signed (Month, Day, Year) 4/3/07	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) James Harring 102 Centennial St La Plata MD 20646							
31. Date filed (Month, Day, Year) APR 03 2007		32. Registrar's Signature 					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 12053

1- For State Registrar

Physician /Medical Examiner

Funeral Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division or Vital Records, P.O. Box 68760,

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year		3. Time of Death	
<i>JOAN MARUCHA</i>		3 26 07		22:31 M	
4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of Death		4c. County of Death	
<i>BWAC</i>		<i>Glen Burnie</i>		<i>AA</i>	
5. Social Security Number	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 79 Yrs.	If Under 1 Year Months Days Hours Min.	8. Date of Birth (Month, Day, Year) 5/9/1927	
093-20-1077				9. Birthplace (State or Foreign Country) PA	
Usual Residence of Decedent		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
10a. State MD	10b. County Anne Arundel	10c. City, Town or Location Odenton			
10e. Street and Number 352 Baltimore Ave.			10f. Zip Code 21113		10g. Citizen of What Country? USA
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: White		14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Homemaker		16b. Kind of Business/Industry Own Home	
17. Father's Name (First, Middle, Last) Eugene Dunn			18. Mother's Name (First, Middle, Maiden Surname) Anna Lytel		
19a. Informant's Name/Relationship (Type, Print) Felix Marucha Husband		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 352 Baltimore Ave. Odenton, MD 21113			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Md Veterans Cemetery		Date 3/30/2007	20c. Location - City or Town, State Crownsville, MD
21. Signature of Funeral Service Licensee <i>John</i>		22. Name and Address of Facility Hardesty Funeral Home, P.A. 12 Ridgely Ave. Annapolis, MD 21401			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)					
a. Due to (or as a consequence of): <i>SORENAH CHRIST</i>					
b. Due to (or as a consequence of): <i>Atrial fibrillation</i>					
c. Due to (or as a consequence of): <i>Diabetes mellitus</i>					
d. _____					
Approximate Interval Between Onset and Death					
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown <input type="checkbox"/> Other (specify) _____			
23d. Date of delivery Month Day Year					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					
23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide	28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred
28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier <i>Christopher T. King</i>					
29c. License number 053283					
29d. Date signed (Month, Day, Year) 3/28/07					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Christopher T. King 1132 Sarapto Rd Odenton MD 21113</i>					
31. Date filed (Month, Day, Year) MAR 3 0 2007		32. Registrar's Signature <i>Barbara A. Jones</i>			

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 12064

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Margaret Ellen Rinehart					2. Date of Death Month April Day 7 Year 2007	3. Time of Death 4:50P M								
	4a. Facility Name (If not institution, give street and number) Westminster Nursing & Rehab. Center		4b. City, Town, or Location of Death Westminster			4c. County of Death Carroll									
Funeral Director	5. Social Security Number 217-28-0922		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) Yrs. 99	If Under 1 Year Months	If Under 24 Hrs. Days Hours Min.	8. Date of Birth (Month, Day, Year) Feb. 18, 1908	9. Birthplace (State or Foreign Country) Maryland							
	Usual Residence of Decedent 10a. State Maryland		10b. County Carroll			10c. City, Town or Location Westminster			10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No						
To Be Completed by Funeral Director	10e. Street and Number 1234 Washington Rd.			10f. Zip Code 21157			10g. Citizen of What Country? U.S.A.								
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 7				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) seamstress				16b. Kind of Business/Industry sewing factory							
17. Father's Name (First, Middle, Last) Samuel Otto					18. Mother's Name (First, Middle, Maiden Surname) Lillie Mae Fritz										
19a. Informant's Name/Relationship (Type, Print) Sam R. Leppo II/great grandson					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3230 Old Taneytown Rd. Westminster, MD 21158										
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Mountain View Cem.			Date 4/10/2007	20c. Location - City or Town, State Union Bridge, MD								
21. Signature of Funeral Service Licensee <i>Catharine O. Hartzler</i>					22. Name and Address of Facility Hartzler Funeral Home 6 E. Broadway Union Bridge, MD 21791										
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last										Approximate Interval Between Onset and Death >5 years					
<p>a. Due to (or as a consequence of): Advanced Stage Dementia</p> <p>b. Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. Due to (or as a consequence of):</p>															
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown			23c. If yes, outcome pf pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year									
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown					
										24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide									
28a. Date of Injury (Month, Day Year)			28b. Time of Injury			28c. Injury at Work? M 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred								
28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State)									
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.						29c. License number 00059552			29d. Date signed (Month, Day, Year) 4/9/07						
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GOURISH RATHOR C. M.D.															
31. Date filed (Month, Day, Year) APR 16 2007			32. Registrar's Signature <i>Jeanne M. Baile</i>												

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural" or items 29a or 29a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

#23a

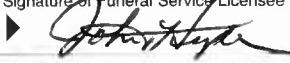
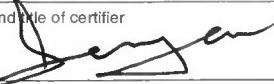
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For Amend Item 2 per dr., g867, 05/23/07.dhb

Certificate of Death

Reg. No. 2007 12055

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) DONALD MAX STECKER				2. Date of Death 03/30/2007	3. Time of Death MARCH 30 2007 12:36 AM
	4a. Facility Name (If not institution, give street and number) Civista Medical Center				4b. City, Town, or Location of Death La Plata	4c. County of Death Charles
Funeral Director	5. Social Security Number 578-38-3814	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 84 Yrs.	If Under 1 Year Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Jan. 9, 1923	9. Birthplace (State or Foreign Country) Ohio	
To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State Maryland 10b. County Charles 10c. City, Town or Location Waldorf				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	10e. Street and Number 2760 Sprague Drive				10f. Zip Code 20601	10g. Citizen of What Country? US
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: WWII		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: White	14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 3 Iron Worker	16b. Kind of Business/Industry Construction		
	17. Father's Name (First, Middle, Last) George Allen Stecker				18. Mother's Name (First, Middle, Maiden Surname) Betty Betts	
	19a. Informant's Name/Relationship (Type, Print) Donna Zorn - Daughter		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2760 Sprague Drive, Waldorf, MD 20601			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) MD Veterans' Cemetery 4-4-07		20b. Place of Disposition (Name of cemetery, crematory or other place) Huntt Funeral Home	Date 3035 Old Washington Road	20c. Location - City or Town, State Cheltenham, MD	
Physician /Medical Examiner	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility 3035 Old Washington Road Huntt Funeral Home Waldorf, MD 20601			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) ACUTE PNEUMONIA				Approximate Interval Between Onset and Death 1 WEEK	
	23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown				23d. Date of delivery Month Day Year	
	23c. If yes, outcome pf pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown				23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
Medical Certification: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DEMENTIA				24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred
	28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)	
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier 			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NELSON BENJAMINS, 9131 PISCATAWAY ROAD, CLINTON, MD 20735		32. License number D 28281		29d. Date signed (Month, Day, Year) MARCH 30, 2007	
State Registrar	31. Date filed (Month, Day, Year) APR 03 2007		32. Registrar's Signature 			

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit once.

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 12066

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Ronald Keith Scheydt						2. Date of Death Month 3 Day 26 Year 2007	3. Time of Death 1942 M		
	4a. Facility Name (If not institution, give street and number) Hartley Hall			4b. City, Town, or Location of Death Pocomoke			4c. County of Death Worcester			
Funeral Director	5. Social Security Number 213-30-3068	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) Yrs. 73	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) 4-22-1933	9. Birthplace (State or Foreign Country) Baltimore City			
	Usual Residence of Decedent 10a. State MD 10b. County Worcester 10c. City, Town or Location Stockton						10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
To Be Completed by Funeral Director	10e. Street and Number 6305 George Island Landing Road			10f. Zip Code 21864			10g. Citizen of What Country? USA			
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 1953- If Yes, Give Year or Dates: 1955	13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 4			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Supervisor			16b. Kind of Business/Industry Metal Refinery			
	17. Father's Name (First, Middle, Last) Edgar Wilbur Scheydt				18. Mother's Name (First, Middle, Maiden Surname) Ida Meyer					
	19a. Informant's Name/Relationship (Type, Print) Shirley Scheydt - wife			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6305 George Island Landing Road, Stockton, MD 21864						
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Crematory of Delmarva			Date 3-29-07	20c. Location - City or Town, State Delmar, Delaware		
	21. Signature of Funeral Service Licensee ► Maura Harry Blake			22. Name and Address of Facility Bounds Funeral Home 705 E. Main Street, Salisbury, Maryland 21804						
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death	
	<p>a. Due to (or as a consequence of): CIRRHOSIS OF LIVER</p> <p>b. Due to (or as a consequence of): NON HODGKIN'S LYMPHOMA</p> <p>c. Due to (or as a consequence of):</p> <p>d. _____</p>									
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year			
Medical Certification: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
							24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	28c. Injury at Work? M <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred			
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
	29b. Signature and title of certifier ► Satyal MD			29c. License number D 0062172			29d. Date signed (Month, Day, Year) 3/27/2007			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SHARAD R SATYAL, MD 1604 MARKET ST POCOMOKE CITY MD 21851.									
State Registrar	31. Date filed (Month, Day, Year) MAR 30 2007			32. Registrar's Signature Renee B. Gandy						

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit once.

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, Medical Examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 12067

1- For
State
Registrar

NAME KNOWN TO PHYSICIAN: HENRY F. TAYLOR
Baltimore, Maryland 21215-0036
Permit, Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last)				2. Date of Death Month Day Year	3. Time of Death	
	HENRY FRANKLIN TAYLOR				APRIL 6 2007	7:00 P.M.	
Funeral Director	4a. Facility Name (If not institution, give street and number)			4b. City, Town, or Location of Death		4c. County of Death	
	VA MARYLAND HEALTH CARE SYSTEM			PERRY POINT		CECIL	
5. Social Security Number		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 73 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) 4/16/1933	9. Birthplace (State or Foreign Country) Virginia
Usual Residence of Decedent		10a. State MD.		10b. County Harford		10c. City, Town or Location Jarrettsville	
10e. Street and Number 4028 Federal Hill Road		10f. Zip Code 21084		10g. Citizen of What Country? United States		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: 1952 1961		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Sheet Metal Supervisor		16b. Kind of Business/Industry United States Army		16c. Date of Death 4/10/2007	
17. Father's Name (First, Middle, Last) James M. Taylor		18. Mother's Name (First, Middle, Maiden Surname) Effie Louise Lamerson					
19a. Informant's Name/Relationship (Type, Print) Dorothy J. Taylor (Wife)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4028 Federal Hill Rd. Jarrettsville, Md.					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) Dulaney Valley		20b. Place of Disposition (Name of cemetery, crematory or other place)		Date	20c. Location - City or Town, State Timonium, Maryland		
21. Signature of Funeral Service Licensee ► M. H. Hackett Kurtz		22. Name and Address of Facility Jarrettsville, Maryland E.G. Kurtz & Son Funeral Home, P.A.					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) LUNG CANCER							
a. Due to (or as a consequence of):							
b. Due to (or as a consequence of):							
c. Due to (or as a consequence of):							
d. Due to (or as a consequence of):							
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____		23d. Date of delivery Month Day Year			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown							
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred	
		28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29c. License number D52739		29d. Date signed (Month, Day, Year) APRIL 6, 2007			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SURESH SHANDELYA, M.D., VA MARYLAND HEALTH CARE SYSTEM, PERRY POINT, MD 21902							
31. Date filed (Month, Day, Year) APR 16 2007		32. Registrar's Signature Suresh Shandelya					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 12068

1. For State Registrar**Physician/
Medical Examiner**

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death 0235 hrs
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Tavarro DeAngelo Walker

April 8, 2007

Funeral Director

4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
--	--------------------------------------	---------------------

Fort Washington Medical Center

Fort Washington

Prince George's

5. Social Security Number	6. Sex	7. Age (In yrs last birthday)	If Under 1 Year	If Under 24 Hrs	8. Date of Birth (MM/DD/YYYY)	9. Birthplace (State or Foreign Country)
---------------------------	--------	-------------------------------	-----------------	-----------------	-------------------------------	--

578-94-8692

XX M

F

32

Yrs

Months

Days

Hours

Min

April 1, 1975

Washington DC

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
------------	-------------	-----------------------------	-------------------------

MD

Prince George's

Oxon Hill

1 XX Yes 2 No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
------------------------	---------------	-------------------------------

2427 W. Rosecroft Village Circle

20745

USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
--------------------	---	---	--

1 XX Never Married 2 Married3 Widowed 4 Divorced1 Yes 2 XX No

If Yes, Give Year or Dates:

1 Yes 2 XX No specify:

Specify: Black

15. Decedent's Education (Specify only highest grade completed)	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
---	---	--------------------------------

Elementary/Secondary (0-12) /

College (1-4 or 5+)

5

Accountant

Pvt.

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
---	---

Earl C. Price

Georgia D. Jordan

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
--	---

Richard Bellamy/Brother

503 Valley Avenue S.E. #4 Washington, DC 20032

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
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1 XX Burial 2 Cremation 3 Removal from State4 Donation 5 Other Specify

Sandridge Com. Cem.

4/15/07

Conway, SC

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
---	----------------------------------

AGEE/MCKINNON Funeral Service

3821 14th Street, NW, Washington, DC 20011

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.	Approximate Interval Between Onset and Death
---	--

Immediate Cause (Final disease or condition resulting in death)

a. Viral syndrome

Due to (or as a consequence of):

b. _____ Due to (or as a consequence of):

c. _____ Due to (or as a consequence of):

d. _____

<input checked="" type="checkbox"/> UNPENDED	<input checked="" type="checkbox"/> AMENDED Item 5, per FH, G868, 6/14/07, WS #23a, 27, per ME, g866, 4/30/07 IT
--	---

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery
---	-----------------------------------	-----------------------

1 Yes 2 No 9 Unknown1 Live birth 2 Fetal death 3 Ectopic pregnancy4 Pregnant at time of death5 Other (Specify)9 Unknown

Month Day Year

23e. Did tobacco use contribute to the cause of death?
--

1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
--------------------------------	---

1 Yes 2 No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)
--	-------------------------------------

1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other

27. Manner of Death	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
---------------------	--	---------------------	----------------------	-----------------------------------

1 XX Natural 5 Pending Investigation
2 Accident 6 Could not be determined
3 Suicide 7 Homicide
4 Homicide

28a. Date of Injury (Month, Day, Year)

1 Yes 2 No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)
--	--

29a. Certifier 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one)	2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
--	---

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
---------------------------------------	---------------------	-------------------------------------

14
Jack Titus MD. Deputy Chief Medical Examiner 111 Penn Street, Baltimore, MD 21201

31. Date filed (Month, Day, Year)	32. Registrar's Signature
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APR 11 2007

ORIGINAL

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, MD 21215-0036

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

State Registrar

DHMH 17 Rev 1/2001
OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 12069

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Janice Marie Windsor							2. Date of Death Month March Day 31 Year 2007	3. Time of Death 6:06 A M
	4a. Facility Name (If not institution, give street and number) Holy Cross Hospital			4b. City, Town, or Location of Death Silver Spring			4c. County of Death Montgomery		
Funeral Director	5. Social Security Number 218-34-6225	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 70 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	Hours	Min.	8. Date of Birth (Month, Day, Year) June 26, 1936	9. Birthplace (State or Foreign Country) Washington DC
	Usual Residence of Decedent								10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
To Be Completed by Funeral Director	10a. State Maryland	10b. County Prince George's	10c. City, Town or Location Upper Marlboro						10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	10e. Street and Number 15800 St. Thomas Church Road	10f. Zip Code 20772			10g. Citizen of What Country? US				
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Head Cashier			16b. Kind of Business/Industry Hardware		
17. Father's Name (First, Middle, Last) Luther J. Etchison, Sr.				18. Mother's Name (First, Middle, Maiden Surname) Frances C. Conover					
19a. Informant's Name/Relationship (Type, Print) Wade Kenneth Windsor, Jr.-Son				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20631 Guard Ct., Gapland, MD 21779					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) Wack A. Wilson				20b. Place of Disposition (Name of cemetery, crematory or other place) St. Thomas Ch. Cem.			Date 04-04-2007	20c. Location - City or Town, State Croom, MD	
21. Signature of Funeral Service Licensee Wack A. Wilson				M01246	22. Name and Address of Facility 3035 Old Washington Road Huntt Funeral Home Waldorf, MD 20601				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Severe Pneumonia								Approximate Interval Between Onset and Death	
a. Due to (or as a consequence of): Severe Pneumonia									
b. Due to (or as a consequence of):									
c. Due to (or as a consequence of):									
d. Due to (or as a consequence of):									
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year				
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Non-Hodgkins Lymphoma								23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
								24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred			
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. ► Maria J. Tayag, MD		29c. License number DR63579			29d. Date signed (Month, Day, Year) 03-31-2007				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Maria J. Tayag, MD, 1500 Forest Glen Road, Silver Spring, MD 20910									
31. Date filed (Month, Day, Year) APR 03 2007		32. Registrar's Signature Janice Marie Windsor							

Baltimore, Maryland 21215-0036

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

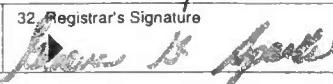
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2007 12070
Reg. No.

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Jean Marie Allison							2. Date of Death Month Day Year April 13, 2007	3. Time of Death 10:07 PM	
	4a. Facility Name (If not institution, give street and number) Prince George General Hospital			4b. City, Town, or Location of Death Cheverly			4c. County of Death Prince George's			
Funeral Director	5. Social Security Number 577 40 5660	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 81 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth Month Day Year Oct 21, 1985	9. Birthplace (State or Foreign Country) Washington DC			
To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State Maryland			10b. County Queen Ann			10c. City, Town or Location Chestertown		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
	10e. Street and Number 125 Primrose Road						10f. Zip Code 21620	10g. Citizen of What Country? United States		
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Secretary		16b. Kind of Business/Industry Government					
	17. Father's Name (First, Middle, Last) Frederick Allison				18. Mother's Name (First, Middle, Maiden Surname) Amelia Lochte					
	19a. Informant's Name/Relationship (Type, Print) Robyn Affron (Niece)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 125 Primrose Road, Chestertown, MD 21620					
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Cedar Hill Cemetery April 20, 2007 Suitland, MD			Date	20c. Location - City or Town, State			
	21. Signature of Funeral Service Licensee  M01464		22. Name and Address of Facility Lee Funeral Home, Inc 6633 Old Alexandria Ferry Road, Clinton, MD 20735							
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Cerebral Vascular Disease								Approximate Interval Between Onset and Death	
Medical Examiner	23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown									
	23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown								23d. Date of delivery Month Day Year	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
									24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA			Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred			
	5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined									
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)								28f. Location (Street and Number or Rural Route Number, City or Town, State)	
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								29b. Signature and title of certifier  Dr. Donald George 3001 Hospital Drive Cheverly MD 20785	
	29c. License number D58182								29d. Date signed (Month, Day, Year) 4-15-07	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)								31. Date filed (Month, Day, Year) APR 17 2007	
	32. Registrar's Signature 								ORIGINAL	

Baltimore, Maryland 21201-50036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2007 12072
Reg. No.1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) DORA ATKINSON							2. Date of Death Month Day Year 04 12 2007	3. Time of Death 10:50 PM	
	4a. Facility Name (If not institution, give street and number) CLINTON NURSING HOME			4b. City, Town, or Location of Death CLINTON			4c. County of Death PRINCE GEORGES			
Funeral Director	5. Social Security Number 242 18 9103	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 87 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) 06-06-1919	9. Birthplace (State or Foreign Country) GREENVILLE, NC			
	Usual Residence of Decedent 10a. State MD 10b. County PRINCE GEORGES 10c. City, Town or Location LANDOVER							10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
To Be Completed by Funeral Director	10e. Street and Number 2404 MUNCY CIRCLE				10f. Zip Code 20785		10g. Citizen of What Country? USA			
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: 8			13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: BLACK			14. Race - American Indian, Black, White, etc. Specify: BLACK		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) DOMESTIC WORKER			16b. Kind of Business/Industry PRIVATE			
	17. Father's Name (First, Middle, Last) CHESTER JENKINS				18. Mother's Name (First, Middle, Maiden Surname) ROBERTA UNKNOWN					
	19a. Informant's Name/Relationship (Type, Print) CHESTER T. HINES/SON			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2404 MUNCY CIRCLE, LANDOVER, MD 20785						
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) ► Julia P. Marshall			20b. Place of Disposition (Name of cemetery, crematory or other place) RESURRECTION CEMETERY			Date 4-18-2007	20c. Location - City or Town, State CLINTON, MD		
	21. Signature of Funeral Service Licensee ► Julia P. Marshall			22. Name and Address of Funeral Home MARSHALL'S FUNERAL HOME OF MD, INC. 4308 SUITLAND RD, SUITLAND, MD 20746						
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to the immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death	
	<p>a. RESPIRATORY FAILURE Due to (or as a consequence of): BILATERAL PNEUMONIA</p> <p>b. STATUS POST TRACHEOSTOMY Due to (or as a consequence of):</p> <p>c. HISTORY OF INTRACRANIAL HEMORRHAGE Due to (or as a consequence of):</p>									
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown			23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year			
Medical Certification: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. S/P PEG								23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
									24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA			26. Place of Death (Check only one) <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide			28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred		
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
	29b. Signature and title of certifier ► K. Davachi				29c. License number D25640			29d. Date signed (Month, Day, Year) 4-13-2007		
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KHOSROW DAVACHI, MD, 7801 OLD BRANCH AVE, #409, CLINTON, MD 20735									
	31. Date filed (Month, Day, Year) APR 17 2007			32. Registrar's Signature Jessica A. Farber						

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

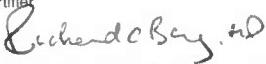
Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23e or 28e-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene
Certificate of Death2007 12073
Reg. No.

1 - For State Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) MILDRED ABRAMOWITZ				2. Date of Death Month APRIL Day 12 Year 2007	3. Time of Death 10:10 AM			
	4a. Facility Name (If not institution, give street and number) 4730 ATRIUM COURT #161		4b. City, Town, or Location of Death OWINGS MILLS			4c. County of Death BALTIMORE			
Funeral Director	5. Social Security Number 213-10-6543	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F X	7. Age (In yrs. last birthday) 94 Yrs.	If Under 1 Year Months 01	If Under 24 Hrs. Days 01	8. Date of Birth (Month, Day, Year) 01/01/1913	9. Birthplace (State or Foreign Country) MD		
To Be Completed by Funeral Director	10a. State MD 10b. County BALTIMORE 10c. City, Town or Location OWINGS MILLS						10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No X		
	10e. Street and Number 4730 ATRIUM COURT #161			10f. Zip Code 21117			10g. Citizen of What Country? U.S.A.		
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married X 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes X <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes X <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: WHITE			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) HOMEMAKER	16b. Kind of Business/Industry OWN HOME						
	17. Father's Name (First, Middle, Last) ABRAHAM	18. Mother's Name (First, Middle, Maiden Surname) GLASSER YETTA MILLEN							
	19a. Informant's Name/Relationship (Type, Print) LESLIE ABRAMOWITZ / SON	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13 PINWOOD FARM COURT - OWINGS MILLS, MD 21117							
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) X	20b. Place of Disposition (Name of cemetery, crematory or other place) ARLINGTON CHIZUK AMUNO	Date 04/15/2007	20c. Location - City or Town, State BALTIMORE, MD					
	21. Signature of Funeral Service Licensee 	22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208							
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							Approximate Interval Between Onset and Death 2 days	
	a. Aspiration pneumonia Due to (or as a consequence of): b. Alzheimer's Disease Due to (or as a consequence of): c. Due to (or as a consequence of): d. 								
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown	23c. If yes, outcome pf pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown	23d. Date of delivery Month Day Year						
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
								24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined	28a. Date of Injury (Month, Day Year) 8/15/2007	28b. Time of Injury M	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred				
	28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) At home							28f. Location (Street and Number or Rural Route Number, City or Town, State) 6101 Reisterstown Rd, Owings Mills, MD 21117	
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.	29c. License number D20604						29d. Date signed (Month, Day, Year) 4/12/07	
	29b. Signature and title of certifier 								
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Richard A. Berg, MD, Suite 450, 10755 Falls Rd, Lutherville, MD 21093								
State Registrar	31. Date filed (Month, Day, Year) APR 17 2007	32. Registrar's Signature 							

Baltimore, Maryland 21215-0036
 Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

6 T

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 12074

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Betty D. Borror						2. Date of Death Month April Day 12, Year 2007	3. Time of Death 8:15 A M
	4a. Facility Name (If not institution, give street and number) Pear Tree Assisted Living			4b. City, Town, or Location of Death Pasadena			4c. County of Death Anne Arundel	
Funeral Director	5. Social Security Number 211-12-7576	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 84 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days Hours Min.	8. Date of Birth (Month, Day, Year) Jan 5, 1923	9. Birthplace (State or Foreign Country) Pennsylvania	
	Usual Residence of Decedent 10a. State Maryland 10b. County Anne Arundel 10c. City, Town or Location Linthicum Heights						10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
To Be Completed by Funeral Director	10e. Street and Number 104 Michael Avenue			10f. Zip Code 21090			10g. Citizen of What Country? USA	
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: 12			13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Administrative Assistant			16b. Kind of Business/Industry Hospital		
17. Father's Name (First, Middle, Last) Ernest Hay				18. Mother's Name (First, Middle, Maiden Surname) Clara Dively				
19a. Informant's Name/Relationship (Type, Print) Paul Borror Jr., Son				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8026 Flora Lane Pasadena, Maryland 21122				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) ► Thomas Gregor			20b. Place of Disposition (Name of cemetery, crematory or other place) Meadowridge Memorial Park			Date 04/16/07	20c. Location - City or Town, State Elkridge, Maryland	
21. Signature of Funeral Service Licensee Thomas Gregor				22. Name and Address of Facility MacNabb Funeral Home, P.A. 301 Frederick Road Catonsville, Maryland 21228				
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) PANCREATIC NEOPLASM Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Approximate Interval Between Onset and Death 13 months							
	23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown			23c. If yes, outcome pf pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year	
Medical Certification: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. HISTORY OF BREAST CANCER, RIGHT S/P RIGHT MODIFIED RADICAL MASTECTOMY (11/01) HYPERTENSION, MITRAL REGURGITATION							
	23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown							
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) Assisted Living						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)						
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier Soon Ja Kim, M.D.				29c. License number D22832			29d. Date signed (Month, Day, Year) 04/12/2007	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Soon Ja Kim, M.D. 5808 MAIN STREET, ELKRIDGE, MD 21075								
31. Date filed (Month, Day, Year) APRIL 17 2007			32. Registrar's Signature Jean B. Spotts					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#22 per FH G866, 4/17/07 WS

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007

12075

1- For State Registrar

Physician /Medical Examiner

Funeral Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

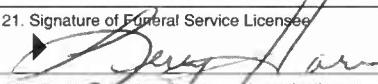
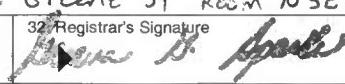
Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month 4 Day 11 Year 2007		3. Time of Death 22:46 M
Antwone Emerick Butler				
4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of Death Baltimore		4c. County of Death N/A
University of Maryland Medical Center				
5. Social Security Number 215-86-3395	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 34 Yrs.	If Under 1 Year Months Days Hours Min.	8. Date of Birth (Month, Day, Year) June 6, 1972
Usual Residence of Decedent Maryland Baltimore		10c. City, Town or Location Randallstown		9. Birthplace (State or Foreign Country) Maryland
10a. State Maryland		10b. County Baltimore		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
10e. Street and Number 3614 Anne Hathaway Drive		10f. Zip Code 21133		10g. Citizen of What Country? USA
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th grade		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+)		16b. Kind of Business/Industry Unemployed
17. Father's Name (First, Middle, Last) Jessie Vonn Yerborough		18. Mother's Name (First, Middle, Maiden Surname) Clara Mae Butler		
19a. Informant's Name/Relationship (Type, Print) Patrice Perkins/Cousin		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6308 Patuxent Quarter Road Hanover, Md 21076		
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) New Cathedral Cemetery		20c. Location - City or Town, State Baltimore, Md 21215
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Chatman-Harris Funeral Home 5240 Reisterstown Rd Baltimore, Md 21215		
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death				
<p><input checked="" type="checkbox"/> Immediate Cause (Final disease or condition resulting in death)</p> <p>a. Urinary tract infection Due to (or as a consequence of):</p> <p>b. Neurogenic bladder Due to (or as a consequence of):</p> <p>c. Spina Bifida Due to (or as a consequence of):</p> <p>d.</p>				
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome pf pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) _____ 9 <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				
23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown				
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
		28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier 		
29c. License number P 21195		29d. Date signed (Month, Day, Year) 4/11/2007		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Joseph Haas 22 S. Greene St Room N3E09 Baltimore, MD 21201				
31. Date filed (Month, Day, Year) APR 17 2007		32. Registrar's Signature 		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 12076

1- For State Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) MAry E. Burton					2. Date of Death Month 04 Day 14 Year 2007	3. Time of Death 9:30 M		
	4a. Facility Name (If not institution, give street and number) Franklin Square Hospital Center			4b. City, Town, or Location of Death Rosedale		4c. County of Death Baltimore			
Funeral Director	5. Social Security Number 217-26-9753	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 76 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) July 3, 1930	9. Birthplace (State or Foreign Country) MARYland		
To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State MD 10b. County Baltimore			10c. City, Town or Location Baltimore			10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
	10e. Street and Number 3907 Hannon Court			10f. Zip Code 21236		10g. Citizen of What Country? USA			
	11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 4 yrs		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Programmer Analyst			16b. Kind of Business/Industry Computer			
	17. Father's Name (First, Middle, Last) William Burton			18. Mother's Name (First, Middle, Maiden Surname) Margaret Milke					
	19a. Informant's Name/Relationship (Type, Print) Gina Shaffer			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 207 Fulford Ave. Bel Air MD 21014					
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Bayview Crematory		Date 4/16/07	20c. Location - City or Town, State Baltimore MD			
	21. Signature of Funeral Service Licensee ► R. Terry Connally		22. Name and Address of Facility 300 Mace Ave. Balto. MD Connally Funeral Home of Essex 21221						
Physician /Medical Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							Approximate Interval Between Onset and Death 1 1/2 years	
Medical Certification: To Be Completed by Physician/Medical Examiner	<p>a. Advanced colon cancer, metastatic Due to (or as a consequence of):</p> <p>b. Severe erosive esophagitis Due to (or as a consequence of):</p> <p>c. _____ Due to (or as a consequence of):</p> <p>d. _____</p>								
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome pf pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 9 <input type="checkbox"/> Unknown 5 <input type="checkbox"/> Other (specify) _____			23d. Date of delivery Month Day Year			
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred		
			28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
	29b. Signature and title of certifier ► Dr. Hang K. Park M.D.		29c. License number RES 00000			29d. Date signed (Month, Day, Year) April 14, 2007			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Hang K. Park M.D., 9000 Franklin Square Drive, Baltimore MD 21237								
State Registrar	31. Date filed (Month, Day, Year) APR 17 2007		32. Registrar's Signature John A. Spangler						

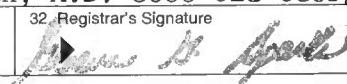
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 12077

1 - For State Registrar

Physician /Medical Examiner		1. Decedent's Name (First, Middle, Last) James Edward Bickings, Sr.						2. Date of Death Month Day Year April 14, 2007		3. Time of Death 11:40 AM	
		4a. Facility Name (If not institution, give street and number) Suburban Hospital			4b. City, Town, or Location of Death Bethesda			4c. County of Death Montgomery			
Funeral Director		5. Social Security Number 579 16 8703	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 84 Yrs.	If Under 1 Year Months Days Hours Min.		8. Date of Birth Month Day Year Nov 22, 1922	9. Birthplace (State or Foreign Country) Washington DC			
		Usual Residence of Decedent 10a. State Maryland 10b. County Prince William 10c. City, Town or Location Dumfries						10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
		10e. Street and Number 3839 Mulberry Point Court			10f. Zip Code 22025			10g. Citizen of What Country? United States			
		11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: 1942-1946	13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: White				14. Race - American Indian, Black, White, etc. Specify: White			
		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Planning Officer					16b. Kind of Business/Industry Dept of Navy		
		17. Father's Name (First, Middle, Last) John J. Bickings, Jr.				18. Mother's Name (First, Middle, Maiden Surname) Adele Revell					
		19a. Informant's Name/Relationship (Type, Print) Charlen Bickings (Daughter)			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3839 Mulberry Point Court, Dumfries, Va 22025						
		20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Cedar Hill Cemetery		Date	20c. Location - City or Town, State April 21, 2007 Suitland, MD				
		21. Signature of Funeral Service Licensee  M01464		22. Name and Address of Facility Lee Funeral Home, Inc. 6633 Old Alexandria Ferry Road, Clinton, MD 20735							
Physician /Medical Examiner		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Cardiogenic Shock Due to (or as a consequence of): Ischemic Cardiomyopathy Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death Five Days	
		b. Due to (or as a consequence of): Ischemic Cardiomyopathy c. Due to (or as a consequence of): Ischemic Cardiomyopathy d. Due to (or as a consequence of): Ischemic Cardiomyopathy								Ten Years	
		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome pf pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown						23d. Date of delivery Month Day Year	
		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
		25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						23f. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
		27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
		28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)								28f. Location (Street and Number or Rural Route Number, City or Town, State)	
		29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29c. License number D52451						29d. Date signed (Month, Day, Year) April 14, 2007	
		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Michael A. Westerman, M.D. 8600 Old Georgetown Road, Bethesda, MD 20814								31. Date filed (Month, Day, Year) APR 17 2007	
		32. Registrar's Signature 								ORIGINAL	

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Bickings, James 14/04/2007
Division or Vital Records, P.O. Box 68760, 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 12078

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Aris C. Braxton, Sr.							2. Date of Death Month Day Year April 9, 2007	3. Time of Death 7:30 AM
	4a. Facility Name (If not institution, give street and number) Life Spring Elder Care			4b. City, Town, or Location of Death Temple Hills			4c. County of Death Prince George's		
Funeral Director	5. Social Security Number 239 16 7499	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 84 Yrs.	If Under 1 Year Months 84	If Under 24 Hrs. Hours 0	Min. 0	8. Date of Birth (Month, Day, Year) July 7, 1922	9. Birthplace (State or Foreign Country) North Carolina	
To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State Maryland 10b. County Prince George 10c. City, Town or Location Temple Hills							10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No X	
	10e. Street and Number 4107 Buck Creek Road			10f. Zip Code 20748			10g. Citizen of What Country? United States		
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: XX 1944			13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: African American			14. Race - American Indian, Black, White, etc. African American	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Foundry Worker			16b. Kind of Business/Industry Gov't Printing Office		
	17. Father's Name (First, Middle, Last) Robert Braxton				18. Mother's Name (First, Middle, Maiden Surname) Janie Pearson				
	19a. Informant's Name/Relationship (Type, Print) Carolyn Eaton (Daughter)			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7702 Kepper Place, Clinton, MD 20735					
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) Lee Funeral Home Crematory			20b. Place of Disposition (Name of cemetery, crematory or other place) Lee Funeral Home Crematory			20c. Location - City or Town, State Clinton, Maryland		
	21. Signature of Funeral Service Licensee MO1464			22. Name and Address of Facility Lee Funeral Home, Inc 6633 Old Alexandria Ferry Road, Clinton, MD 20735					
Physician /Medical Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Terminal Prostate Cancer Due to (or as a consequence of): Multiple Myeloma b. Due to (or as a consequence of): c. Terminal State Alzheimer Dementia Due to (or as a consequence of): d.								Approximate Interval Between Onset and Death
	23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown			23c. If yes, outcome pf pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year		
Medical Certification: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown X
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DDA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) Residence			23f. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown X		
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide			28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred	
				28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.			29c. License number D 31528			29d. Date signed (Month, Day, Year) April 11, 2007		
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Margaret Akpan, M.D. 6128 Landover Road, Landover, MD								
State Registrar	31. Date filed (Month, Day, Year) APR 17 2007		32. Registrar's Signature Leanne B. Appling						

Division or Vital Records, P.O. Box 68760, US

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

1
State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

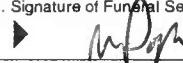
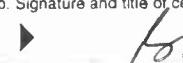
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2007 12079

Reg. No.

For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last)							2. Date of Death			3. Time of Death				
	Collin Bates							Month	Day	Year					
Funeral Director	4a. Facility Name (If not institution, give street and number)				4b. City, Town, or Location of Death			4c. County of Death							
	St. Agnes Hospital				Baltimore			Baltimore							
5. Social Security Number		6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	9. Birthplace (State or Foreign Country)								
N/A		<input checked="" type="checkbox"/> M <input type="checkbox"/> F	Yrs.	Months	Days	Hours	Min.	Month	Day	Year					
				13				March	31	2007					
4. Usual Residence of Decedent															
10a. State		10b. County		10c. City, Town or Location							10d. Inside City Limits				
Maryland		Baltimore		Halethorpe							<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
10e. Street and Number				10f. Zip Code				10g. Citizen of What Country?							
5655 Braxfield Rd.				21227				USA							
11. Marital Status			12. Was Decedent Ever in U.S. Armed Forces?			13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)			14. Race - American Indian, Black, White, etc.						
<input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:			<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			Specify: White						
15. Decedent's Education (Specify only highest grade completed)			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)			16b. Kind of Business/Industry									
Elementary/Secondary (0-12) N/A			College (1-4 or 5+)			N/A			N/A						
17. Father's Name (First, Middle, Last)						18. Mother's Name (First, Middle, Maiden Surname)									
Ronald Bates						Marie Wainglass									
19a. Informant's Name/Relationship (Type, Print)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)											
Marie Bates- mother				5655 Braxfield Rd., Halethorpe, MD 21227											
20a. Method of Disposition				20b. Place of Disposition (Name of cemetery, crematory or other place)				20c. Location - City or Town, State							
<input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				Metro Crematory				Date April 13, 2007 Catonsville, MD							
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Gary L. Kaufman Funeral Home at MMP, INC. 7250 Washington Blvd., Elkridge, MD 21075											
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.															
Immediate Cause (Final disease or condition resulting in death) Pulmonary Interstitial Emphysema Approximate Interval Between Onset and Death 4 days old															
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last															
{ a. Due to (or as a consequence of): Severe Respiratory Distress Birth b. Due to (or as a consequence of): Extreme Prematurity at 23 wks Birth c. Due to (or as a consequence of): d. _____															
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Unknown						23d. Date of delivery Month Day Year							
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.															
Grade IV intraventricular hemorrhage															
Fungal sepsis															
Renal failure															
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide				28a. Date of Injury (Month, Day Year)		28b. Time of Injury		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred					
				M											
29a. Certifier <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)								28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29b. Signature and title of certifier 				29c. License number D023368				29d. Date signed (Month, Day, Year) April 12, 2007							
30. Name and address of person who completed cause of death (Item 2a) (Type, Print)				32. Registrar's Signature 											
SIEW JYU WONG				St Agnes Hospital, Baltimore, MD											
31. Date filed (Month, Day, Year)				32. Registrar's Signature											
APR 17 2007				Kathy A. Bates											

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit slip.

Medical Certification: To Be Completed by Physician/Medical Examiner

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a show any injury or other traumatic event, the Medical Examiner must be notified at 301-495-5200.

State Registrar

Baltimore, Maryland 21215-0036

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 12080

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Ethel May Bukovsky							2. Date of Death Month Day Year April 16, 2007	3. Time of Death 8:50 A M
	4a. Facility Name (If not institution, give street and number) 1705 Pot Spring Road			4b. City, Town, or Location of Death Timonium			4c. County of Death Baltimore		
Funeral Director	5. Social Security Number 216-24-3736	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 79 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) Feb. 29, 1928	9. Birthplace (State or Foreign Country) Maryland		
	10a. State Maryland			10b. County Baltimore			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
10e. Street and Number 1705 Pot Spring Road				10f. Zip Code 21093			10g. Citizen of What Country? U.S.A.		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced				12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Disability Claims Processor			16b. Kind of Business/Industry State of Maryland		
17. Father's Name (First, Middle, Last) John Forsigh				18. Mother's Name (First, Middle, Maiden Surname) Florence Watt					
19a. Informant's Name/Relationship (Type, Print) Dale Salah Daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1705 Pot Spring Road Timonium, Maryland 21204					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) Paul J. Hayes				20b. Place of Disposition (Name of cemetery, crematory or other place) Oak Lawn Cemetery			Date 4-19-2007	20c. Location - City or Town, State Baltimore Maryland	
21. Signature of Funeral Service Licensee Dale Salah Daughter				22. Name and Address of Facility Ruck Towson Funeral Home, Inc.					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Coronary Artery Disease							Approximate Interval Between Onset and Death		
Immediate Cause (Final disease or condition resulting in death)				a. Due to (or as a consequence of): Coronary Artery Disease					
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				b. Due to (or as a consequence of):					
				c. Due to (or as a consequence of):					
				d. Due to (or as a consequence of):					
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown					23d. Date of delivery Month Day Year		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. BORDELLERIA, Atherosclerosis, Hypertension, Myocardial infarction				23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide				28a. Date of Injury (Month, Day, Year) 4-16-07	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred		
				28e. Place of Injury: At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29c. License number D33361					
29b. Signature and title of certifier Albert J. Hayes, MD				29d. Date signed (Month, Day, Year) 4-16-07					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) D. Albert Hayes, MD 35 E. Padonia Rd				31. Date filed (Month, Day, Year) APR 17 2007					
				32. Registrar's Signature James B. Hayes					

Baltimore, Maryland 21215-0036

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Name 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760, S.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit slip.

Medical Certification: To Be Completed by Physician/Medical Examiner

8

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2007 1203

1- For State Registrar

Reg. No.

Physician/
Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death 1309 hrs
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Robert Bishop

April 3, 2007

Funeral Director

4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
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Maryland General Hospital

Baltimore

5. Social Security Number	6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) 64 Yrs.	If Under 1 Year Months Days Hours Min.	8. Date of Birth (MM/DD/YYYY) Aug 10, 1942	9. Birthplace (State or Foreign Country) unk
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Usual Residence of Decedent

10a. State MD	10b. County	10c. City, Town or Location Baltimore	10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No
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10e. Street and Number 1102 Druid Hill Avenue	10f. Zip Code 21201	10g. Citizen of What Country? USA
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11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: Specify: black	14. Race - American Indian, Black, White, etc.
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15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) unk	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) unk	16b. Kind of Business/Industry unk
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17. Father's Name (First, Middle, Last) O.C.M.E.	18. Mother's Name (First, Middle, Maiden Surname) unk
---	--

19a. Informant's Name/Relationship (Type, Print) O.C.M.E.	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 111 Penn Street Baltimore, MD 21201
--	--

20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input checked="" type="checkbox"/> Other Specify: in state	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
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21. Signature of Funeral Service Licensee Ronald S. Wade, Director <i>Ronald S. Wade</i>	22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201
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Baltimore, MD 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 2 should be detached for use as the burial - transit

Physician
Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.	Approximate Interval Between Onset and Death
---	--

Immediate Cause (Final disease or condition resulting in death) a. Occlusive pulmonary thromboembolism Due to (or as a consequence of):	
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Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. deep venous thromboses Due to (or as a consequence of):	
---	--

c. remote leg fracture Due to (or as a consequence of):	
--	--

d.	
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<input checked="" type="checkbox"/> UNPENDED <input type="checkbox"/> AMENDED #23a-c, 27, 28a-f, per ME, g866, 4/18/07 TT	23d. Date of delivery Month Day Year
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IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown	23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown	23d. Date of delivery Month Day Year
--	---	---

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown
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<hr/> <hr/>	24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No
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25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	26. Place of Death (Check only one) Hospital 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other:
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27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input checked="" type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Homicide 4 <input type="checkbox"/> Homicide	28a. Date of Injury (Month, Day, Year) unknown	28b. Time of Injury unknown	28c. Injury at Work? unk 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred Motor vehicle accident
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28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State) unk. unk.
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29a. Certifier 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check only one) 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.	29b. Signature and title of certifier <i>Carol Allan</i>	29c. License number O.C.M.E.	29d. Date signed (Month, Day, Year) April 4, 2007
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30. Name and address of person who completed cause of death (Item 23a) Carol Allan, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

31. Date filed (Month, Day, Year) APR 17 2007	32. Registrar's Signature <i>Robert Bishop</i>
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene
Certificate of Death

Reg. No.

2007 12082

1- For
State
Register

Physician
/Medical
Examiner

Permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

		1. Decedent's Name (First, Middle, Last)						2. Date of Death Month Day Year			3. Time of Death		
		CLARENCE TINE JOANN BROOKS						April 9 2007			5:17 PM		
Physician /Medical Examiner		4a. Facility Name (If not institution, give street and number)			4b. City, Town, or Location of Death			4c. County of Death			31. Date filed (Month, Day, Year)		
		HARFORD MEMORIAL HOSPITAL			HAVRE DE GRACE			HARFORD CO			APR 17 2007		
Funeral Director		5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.		8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)		32. Registrar's Signature		
		217-40-7695	1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	64 Yrs.	Months	Days	Hours	JUN 16 1942	MARYLAND		<i>[Signature]</i>		
		Usual Residence of Decedent										33. Date of Report	
		10a. State	10b. County		10c. City, Town or Location						10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
		MARYLAND	HARFORD CO		ABERDEEN								
		10e. Street and Number				10f. Zip Code				10g. Citizen of What Country? U.S.A.			
		601 CORNELL ST. APT 108				21001							
		11. Marital Status		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: BLACK				
		1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced											
		15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)			16b. Kind of Business/Industry						
		Elementary/Secondary (0-12) 12th grade		College (1-4 or 5+)			HOME HEALTH ATTENDANT			HOME HEALTH			
		17. Father's Name (First, Middle, Last)				18. Mother's Name (First, Middle, Maiden Surname)							
		CLARENCE E RIDGLEY				DAISY BELL RIDGLEY							
		19a. Informant's Name/Relationship (Type, Print)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)				11217			
		Clarencetine D. Brooks/Daughter				136 St. Marks Ave., Apt #3, Brooklyn, New York							
		20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place)		Date			20c. Location - City or Town, State				
				UNION UNITED METH,		04-18-07			SWAN CREEK, MARYLAND				
		21. Signature of Funeral Service Licensee 				22. Name and Address of Facility WM C BROWN COMMUNITY FUNERAL HOME-HARFORD, P.A. 321 S PHILADELPHIA BLVD, ABERDEEN, MD 21001							
		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.										Approximate Interval Between Onset and Death	
		Immediate Cause (Final disease or condition resulting in death)											
		a. Respiratory Failure Due to (or as a consequence of):											
		b. Exacerbation COPD Due to (or as a consequence of):											
		c. _____ Due to (or as a consequence of):											
		d. _____											
		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown										23d. Date of delivery Month Day Year	
		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown											
		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown	
		25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No										26. Place of Death (Check only one) 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)	
		27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide										28a. Date of Injury (Month, Day, Year) 28b. Time of Injury M 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)										28d. Describe how injury occurred	
		29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										28f. Location (Street and Number or Rural Route Number, City or Town, State)	
		29b. Signature and title of certifier 										29c. License number H55222	
		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Paul Little 501 S. Union Ave Havre De Grace MD 21073										29d. Date signed (Month, Day, Year) April 10 2007	
		31. Date filed (Month, Day, Year)										32. Registrar's Signature 	
		APR 17 2007											

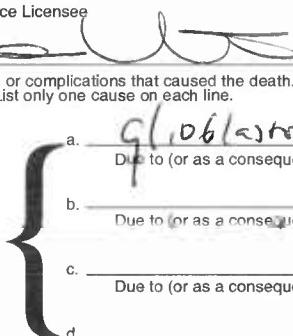
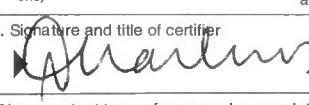
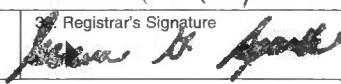
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 12033

1 - For State Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) DORIS D. BUFFINGTON				2. Date of Death Month APRIL Day 12 Year 2007	3. Time of Death 2:50A M		
	4a. Facility Name (If not institution, give street and number) GILCHRIST HOSPICE CENTER		4b. City, Town, or Location of Death TOWSON		4c. County of Death BALTIMORE			
Funeral Director	5. Social Security Number 202-20-5945	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 78 Yrs.	If Under 1 Year Months <input type="checkbox"/> Days Hours <input type="checkbox"/> Min.	If Under 24 Hrs. Hours <input type="checkbox"/> Min.	8. Date of Birth (Month, Day, Year) 5-1-1928	9. Birthplace (State or Foreign Country) PENNSYLVANIA	
To Be Completed by Funeral Director	10a. State MD		10b. County BALTIMORE	10c. City, Town or Location PARKVILLE			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	10e. Street and Number 8800 WALTHER BLVD WALDEN CT APT 1407			10f. Zip Code 21234		10g. Citizen of What Country? U.S.A.		
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: WHITE		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) HOMEMAKER			16b. Kind of Business/Industry OWN HOME		
	17. Father's Name (First, Middle, Last) PAUL DOWNEY			18. Mother's Name (First, Middle, Maiden Surname) EDNA (SMITH)				
	19a. Informant's Name/Relationship (Type. Print) ROBERT BUFFINGTON/HUSBAND			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8800 WALTHER BLVD WALDEN CT APT 1407 PARKVILLE, MD 21234				
Physician /Medical Examiner	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <i>PARKWOOD CEMETERY</i>		20b. Place of Disposition (Name of cemetery, crematory or other place) PARKWOOD CEMETERY		Date 4-16-2007	20c. Location - City or Town, State PARKVILLE, MD		
	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility CVACH/ROSEDALE FUNERAL HOME 1211 CHESACO AVE ROSEDALE, MD 21237					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown							Approximate Interval Between Onset and Death years
	23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____							23d. Date of delivery Month Day Year
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) hospice
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide							28a. Date of Injury (Month, Day Year) M 28b. Time of Injury 28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No 28d. Describe how injury occurred
	28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)							
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							29b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	29b. Signature and title of certifier 							29c. License number D 58303
	30. Name and address of person who completed cause of death (Item 23a) (Type. Print) Aaron J Charles MD 6701 N. Charles St TOWSON MD 21204							29d. Date signed (Month, Day, Year) April 12 2007
State Registrar	31. Date filed (Month, Day, Year) APR 17 2007			32. Registrar's Signature 				

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

10

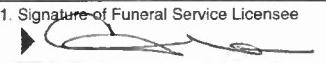
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 12084

1 - For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) EDNA IRENE BUTTINS					2. Date of Death Month APRIL Day 12 , Year 2007	3. Time of Death 3:25P M	
	4a. Facility Name (If not institution, give street and number) Saint Joseph Medical Center					4b. City, Town, or Location of Death Towson	4c. County of Death Baltimore	
Funeral Director	5. Social Security Number 212-24-8954		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 78 Yrs.	If Under 1 Year Months <input type="checkbox"/> Days <input type="checkbox"/>	If Under 24 Hrs. Hours <input type="checkbox"/> Min. <input type="checkbox"/>	8. Date of Birth (Month, Day, Year) 7-6-1928	9. Birthplace (State or Foreign Country) MARYLAND
	10a. State MD		10b. County BALTIMORE	10c. City, Town or Location RASPEBURG				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
10e. Street and Number 5417 HAMILTOWNE AVENUE				10f. Zip Code 21206		10g. Citizen of What Country? U.S.A.		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: Specify: WHITE			14. Race - American Indian, Black, White, etc.	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) MEAT PACKING		16b. Kind of Business/Industry ACME				
17. Father's Name (First, Middle, Last) JOHN SHEARER				18. Mother's Name (First, Middle, Maiden Surname) UNKNOWN (UNKNOWN)				
19a. Informant's Name/Relationship (Type, Print) Daughter JACQUELINE WILLIAMS				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5417 HAMILTOWNE AVE BALTIMORE, MD 21206				
20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input checked="" type="checkbox"/> Other (Specify) ENCOIMBMENT		20b. Place of Disposition (Name of cemetery, crematory or other place) HOLLY HILL CEMET			Date 4-16-07	20c. Location - City or Town, State MIDDLE RIVER, MD		
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility CVACH / ROSEDALE FUNERAL HOME 1211 CHESACO AVENUE ROSEDALE, MD 21237						
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.								
Immediate Cause (Final disease or condition resulting in death) REFRACTORY VENTRICULAR FIBRILLATION								
Approximate Interval Between Onset and Death 1 HOUR								
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								
{ a. Due to (or as a consequence of): MYOCARDIAL SCARRING b. Due to (or as a consequence of): c. CORONARY ARTERY DISEASE d. Due to (or as a consequence of):								
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome pf pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____ <input type="checkbox"/> Unknown					23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								
23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown								
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred		
		28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29c. License number D30446						
29b. Signature and title of certifier 		29d. Date signed (Month, Day, Year) 4/12/2007						
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PETER J. HORNEFFER M. D. 7601 OSLER DRIVE TOWSON, MARYLAND 21204								
31. Date filed (Month, Day, Year) APR 17 2007		32. Registrar's Signature 						

Baltimore, Maryland 21215-0036

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene
Certificate of Death2007 12085
Reg. No.1- For
State
RegistrarPhysician
/Medical
Examiner

Baltimore, Maryland 21215-0036

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

State
Registrar

		1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year		3. Time of Death			
		Joan F. Baumgardner		April 11, 2007		11:08 P M			
4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of Death		4c. County of Death					
752 220th Street		Pasadena		Anne Arundel					
5. Social Security Number		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 65 Yrs.	If Under 1 Year Months Days Hours Min.	If Under 24 Hrs.	8. Date of Birth (Month, Day, Year) March 30, 1942	9. Birthplace (State or Foreign Country) MD		
Usual Residence of Decedent		10a. State MD		10b. County Anne Arundel		10c. City, Town or Location Pasadena		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number 752 220th Street				10f. Zip Code 21122		10g. Citizen of What Country? U.S.A.			
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Waitress		16b. Kind of Business/Industry Food					
17. Father's Name (First, Middle, Last) John Maliszewski		18. Mother's Name (First, Middle, Maiden Surname) Florence LaMartina							
19a. Informant's Name/Relationship (Type, Print) Mrs. Lori Warren/ Daughter		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 104 Round Ridge Road Mechanicsburg, PA 17055		20b. Place of Disposition (Name of cemetery, crematory or other place) Cedar Hill Cemetery		Date April 14, 2007	20c. Location - City or Town, State Brooklyn Park, MD		
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		21. Signature of Funeral Service License ► <i>John Maliszewski</i> MO1364		22. Name and Address of Facility Singleton Funeral Home, P.A. 1 Second Avenue SW, Glen Burnie, MD 21061					
<p>23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.</p> <p>Immediate Cause (Final disease or condition resulting in death) BRAIN CARBONATE</p> <p>Approximate Interval Between Onset and Death 12 months</p> <p>Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</p> <p>a. Due to (or as a consequence of):</p> <p>b. Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. Due to (or as a consequence of):</p>									
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify)		23d. Date of delivery Month Day Year					
<p>Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.</p> <p>23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown</p>									
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year) MAY 12 2007		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29b. Signature and title of certifier ► <i>Lori Warren</i>		29c. License number 047934		29d. Date signed (Month, Day, Year) APRIL 12, 2007					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Lori Warren MD 727 St Paul St Baltimore MD 21202									
31. Date filed (Month, Day, Year) APR 17 2007		32. Registrar's Signature <i>Laura B. Apelle</i>							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 12086

1 - For State Registrar

Physician /Medical Examiner

Funeral Director

Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

APRIL 13, 2007 1:00 p.m.

Baltimore, Maryland 21215-0036

JOSEPH BROWN
Division or Vital Records, P.O. Box 68760, F

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year				3. Time of Death				
JOSEPH BROWN		APR.13, 2007				1P M				
4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of Death				4c. County of Death				
STELLA MARIS - DULANEY		TIMONIUM				BALTIMORE				
5. Social Security Number		6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)			
212 24 7759		<input checked="" type="checkbox"/> M <input type="checkbox"/> F	79 Yrs.	Months	Days	Hours	Min.	AUG.1, 1927	VIRGINIA	
10a. State		10b. County		10c. City, Town or Location				10d. Inside City Limits		
MD.		BALTIMORE		ESSEX				<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
10e. Street and Number		10f. Zip Code				10g. Citizen of What Country?				
1512 ALCONBURY ROAD		21221				USA				
11. Marital Status		12. Was Decedent Ever in U.S. Armed Forces?		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)				14. Race - American Indian, Black, White, etc.		
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				Specify: BLACK		
15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)				16b. Kind of Business/Industry				
Elementary/Secondary (0-12) 7TH		College (1-4 or 5+) TRUCK DRIVER				TRUCKING INDUSTRY				
17. Father's Name (First, Middle, Last)					18. Mother's Name (First, Middle, Maiden Surname)					
JAMES BROWN					NANNIE					
19a. Informant's Name/Relationship (Type, Print)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)								
CLARENE JACKSON (daughter)		1512 ALCONBURY ROAD.				ESSEX, MD 21221				
20a. Method of Disposition		20b. Place of Disposition (Name of cemetery, crematory or other place)		Date		20c. Location - City or Town, State				
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		GREEN MOUNT CREMATORI		APR.19, 2007		BALTIMORE, MD.				
21. Signature of Funeral Service Licensee		22. Name and Address of Facility								
<i>Bernadine T. Scruggs</i>		CALVIN B. SCRUGGS FUNERAL HOME 1412 E. PRESTON ST. BALTO, MD. 21213								
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.										
Immediate Cause (Final disease or condition resulting in death)										
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last										
<p>a. SEPSIS Due to (or as a consequence of):</p> <p>b. _____ Due to (or as a consequence of):</p> <p>c. _____ Due to (or as a consequence of):</p> <p>d. _____</p>										
Approximate Interval Between Onset and Death										
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) _____				23d. Date of delivery Month Day Year				
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										
23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown										
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No										
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No										
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) HOSPICE								
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred			
29a. Certifier (Check only one)		28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)								
29b. Signature and title of certifier <i>[Signature]</i>		29c. License number <i>D43725</i>				29d. Date signed (Month, Day, Year) <i>4/13/07</i>				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)										
DR. TARIQ MAHMOOD 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093										
31. Date filed (Month, Day, Year) <i>APR 17 2007</i>		32. Registrar's Signature <i>[Signature]</i>								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 12087

1- For State Registrar

Physician / Medical Examiner	1. Decedent's Name (First, Middle, Last) Catherine Anne Bender							2. Date of Death Month April Day 11 Year 2007	3. Time of Death 8:45 pM
	4a. Facility Name (If not institution, give street and number) Gilchrist				4b. City, Town, or Location of Death Towson			4c. County of Death Baltimore	
Funeral Director	5. Social Security Number 333-32-0236	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 67 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Hours	Min.	8. Date of Birth (Month, Day, Year) July 21, 1939	9. Birthplace (State or Foreign Country) Illinois	
To Be Completed by Funeral Director	10a. State Md. 10b. County N/A 10c. City, Town or Location Baltimore							10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
	10e. Street and Number 15 Devon Hill Road			10f. Zip Code 21210			10g. Citizen of What Country? USA		
Physician / Medical Examiner	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 5+			16b. Kind of Business/Industry Reg. Nurse			16b. Kind of Business/Industry Nursing	
17. Father's Name (First, Middle, Last) John Francis Brosnahan				18. Mother's Name (First, Middle, Maiden Surname) Helen Elizabeth Buswell					
19a. Informant's Name/Relationship (Type, Print) Mrs. Mary Catherine Simmons/ Dtr.				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 611 Wood Glenn Court Lutherville, Md. 21093					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) Dulaney Valley Mem.			20b. Place of Disposition (Name of cemetery, crematory or other place) Dulaney Valley Mem.			Date 4-17-07	20c. Location - City or Town, State Timonium, Md.		
Medical Certification: To Be Completed by Physician/Medical Examiner		21. Signature of Funeral Service Licensee 							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Lung Cancer									
Approximate Interval Between Onset and Death months									
23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown									
23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____									
23d. Date of delivery Month Day Year									
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									
23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown									
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No									
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No									
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No									
26. Place of Death (Check only one) Hospital <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) Hospital									
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide									
28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No									
28d. Describe how injury occurred									
28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)									
28f. Location (Street and Number or Rural Route Number, City or Town, State)									
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
29b. Signature and title of certifier 									
29c. License number D58303									
29d. Date signed (Month, Day, Year) April 12 2007									
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ANNE J. CHARLES MD 6701 N. Charles St Towson MD 21204									
State Registrar	31. Date filed (Month, Day, Year) APR 17 2007		32. Registrar's Signature 						

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

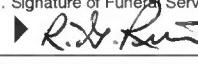
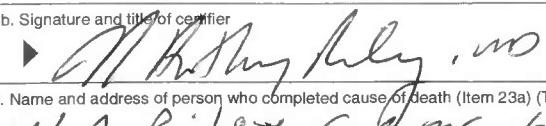
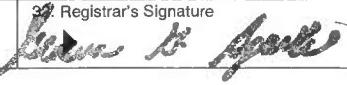
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 12088

1- For State Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) FLORENCE V. BITTNER				2. Date of Death Month APRIL Day 12 , Year 2007	3. Time of Death 11:59 P.M.	
	4a. Facility Name (If not institution, give street and number) HOSPICE OF BALTIMORE GILCHRIST CENTER		4b. City, Town, or Location of Death TOWSON		4c. County of Death BALTIMORE		
Funeral Director	5. Social Security Number 217-09-5419	6. Sex <input checked="" type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 88 Yrs.	If Under 1 Year Months <input type="text"/> Days <input type="text"/> Hours <input type="text"/> Min. <input type="text"/>	8. Date of Birth (Month, Day, Year) 05-06-1918	9. Birthplace (State or Foreign Country) MARYLAND	
To Be Completed by Funeral Director	10a. State MD. 10b. County BALTIMORE 10c. City, Town or Location TIMONIUM				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
	10e. Street and Number 12261 ROUNDWOOD ROAD		10f. Zip Code 21093		10g. Citizen of What Country? U. S. A.		
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 YEARS		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) HOUSEWIFE		16b. Kind of Business/Industry OWN HOME		
	17. Father's Name (First, Middle, Last) ANTHONY VOGLE			18. Mother's Name (First, Middle, Maiden Surname) MARGUERITE FINK			
	19a. Informant's Name/Relationship (Type, Print) SUSAN B. JONES (DAUGHTER)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8924 WRIGHTS MILL ROAD, WOODSTOCK, MARYLAND, 21163				
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) DULANEY VALLEY M.G.		Date 04-16-2007	20c. Location - City or Town, State TIMONIUM, MARYLAND	
	21. Signature of Funeral Service Licensee  (R. G. RUTH)		22. Name and Address of Facility RUCK TOWSON FUNERAL HOME, INC. 1050 YORK ROAD TOWSON, MD. 21204				
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last						
	<p>a. Due to (or as a consequence of): <i>Sepsis Syndrome</i></p> <p>b. Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. Due to (or as a consequence of):</p>						
	Approximate Interval Between Onset and Death weeks						
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome pf pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown <input type="checkbox"/> Other (specify)		23d. Date of delivery Month <input type="text"/> Day <input type="text"/> Year <input type="text"/>		
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Dementia, obstructive lung disease</i>						
	23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown						
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No						
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						
	26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) Hospice						
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide						
	28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred		
	28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)						
	28f. Location (Street and Number or Rural Route Number, City or Town, State)						
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.						
	29b. Signature and title of certifier 						
	29c. License number D 25205						
	29d. Date signed (Month, Day, Year) April 13, 2007						
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) W.A. Riley G BMC 6701 N. Charles St. Balto. MD 21208						
	31. Date filed (Month, Day, Year) APR 17 2007		32. Registrar's Signature 				

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2007

12089

1- For State Registrar		2. Date of Death Month Day Year April 11, 2007								3. Time of Death 7:22 A M		
Physician /Medical Examiner		1. Decedent's Name (First, Middle, Last) Ruth A. Bertling				4a. Facility Name (If not institution, give street and number) 2713 Proctor Lane				4b. City, Town, or Location of Death Baltimore	4c. County of Death Baltimore	
Funeral Director		5. Social Security Number 214-24-9691	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 78 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) April 9, 1929	9. Birthplace (State or Foreign Country) Maryland				
To Be Completed by Funeral Director		Usual Residence of Decedent 10a. State Maryland								10b. County Baltimore	10c. City, Town or Location Baltimore	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
		10e. Street and Number 2713 Proctor Lane								10f. Zip Code 21234	10g. Citizen of What Country? U.S.A.	
Physician /Medical Examiner		11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: White			14. Race - American Indian, Black, White, etc. Specify: White			
		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Homemaker			16b. Kind of Business/Industry Own Home						
		17. Father's Name (First, Middle, Last) Paul Leonard	18. Mother's Name (First, Middle, Maiden Surname) Carol A. Walters Daughter Helen Jacob									
		19a. Informant's Name/Relationship (Type, Print) Carol A. Walters Daughter	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1428 Putty Hill Ave. Towson, Maryland 21286									
		20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) Parkwood Cemetery	20b. Place of Disposition (Name of cemetery, crematory or other place) Parkwood Cemetery			Date 2007	20c. Location - City or Town, State Parkville Maryland					
		21. Signature of Funeral Service Licensee Paul A. Hogan	22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Maryland 21204									
		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. METASTATIC CARCINOID TO LIVER, years. Due to (or as a consequence of): b. BONE AND LUNGS Due to (or as a consequence of): c. d. Due to (or as a consequence of): Approximate Interval Between Onset and Death										
		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year						
		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown				
								24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No			
		25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)									
		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred						
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) At home	28f. Location (Street and Number or Rural Route Number, City or Town, State) Towson, Maryland									
		29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.	29c. License number D0025886									
		29b. Signature and title of certifier Lilia Ceballus, M.D.	29d. Date signed (Month, Day, Year) April 16, 2007									
		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Lilia Ceballus, M.D. 7505 Osler Drive Towson, Maryland 21204										
		31. Date filed (Month, Day, Year) APR 17 2007	32. Registrar's Signature lilia b. gomez									

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

amend items 7, 19a, per LG 8664 25-07 yr

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2007 12090

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) VIVIAN C. BRYANT						2. Date of Death Month Day Year 04 10 2007	3. Time of Death 9:30 PM		
	4a Facility Name (If not institution, give street and number) SACRED HEART NURSING HOME			4b. City, Town, or Location of Death HYATTSVILLE			4c. County of Death PRINCE GEORGES			
Funeral Director	5. Social Security Number 236 34 9528	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 85 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth Month, Day, Year 01-26-1921	9. Birthplace (State or Foreign Country) OHIO			
To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State MD 10b. County PRINCE GEORGES 10c. City, Town or Location FORT WASHINGTON								10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
	10e. Street and Number 711 AMER DRIVE			10f. Zip Code 20744			10g. Citizen of What Country? USA			
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: BLACK		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) CLERICAL			16b. Kind of Business/Industry GOVERNMENT			
	17. Father's Name (First, Middle, Last) FREDERICK D. CHANEY				18. Mother's Name (First, Middle, Maiden Surname) ELLA CAIN					
	19a. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 711 AMER DR, FORT WASHINGTON, MD 20744				19b. Place of Disposition (Name of cemetery, crematory or other place) METROPOLITAN CREMATORIUM				Date 4-16-07	20c. Location - City or Town, State ALEXANDRIA, VA
	21. Signature of Funeral Service Licensee 				22. Name and Address of Funeral Home JULIA P. MARSHALL'S FUNERAL HOME OF MD, INC. 4308 SUITLAND RD, SUITLAND, MD 20746					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. e. ATHEROSCLEROTIC CARDIOVASCULAR DISEASE Due to (or as a consequence of): b. _____ Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____								Approximate Interval Between Onset and Death	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. HYPERTENSION								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
									24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
									24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Physician /Medical Examiner	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
Medical Certification: To Be Completed by Physician/Medical Examiner	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred			
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)					
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
	29b. Signature and title of certifier 		29c. License number D52900			29d. Date signed (Month, Day, Year) 04-12-2007				
	30. Name and address of person who completed cause of death (Item 23e) (Type, Print) MUSA MOMOH, MD, 8700 CENTRAL AVE, #301, LANDOVER, MD 20785									
State Registrar	31. Date filed (Month, Day, Year) APR 17 2007		32. Registrar's Signature 							

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 23e-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 23e-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Amend #7,10d, per FH, G866, 4/17/07 T
Registrar Certificate of Death

Reg. No. 2007 12091

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>BRENOA L. BLYWEISS</i>				2. Date of Death Month <input checked="" type="checkbox"/> 4 Day <input checked="" type="checkbox"/> 10 Year <input checked="" type="checkbox"/> 2007	3. Time of Death <input checked="" type="checkbox"/> 11:32 AM		
	4a. Facility Name (If not institution, give street and number) <i>Howard County General Hospital</i>		4b. City, Town, or Location of Death <i>Columbia</i>		4c. County of Death <i>Howard</i>			
Funeral Director	5. Social Security Number <i>170-323636</i>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 66 - Yrs.	If Under 1 Year Months <input type="checkbox"/>	If Under 24 Hrs. Hours <input type="checkbox"/>	8. Date of Birth (Month, Day, Year) <i>09/10/1940</i>	9. Birthplace (State or Foreign Country) <i>PA</i>	
	Usual Residence of Decedent 10a. State <input checked="" type="checkbox"/> Maryland 10b. County <input checked="" type="checkbox"/> Howard 10c. City, Town or Location <i>Columbia</i>				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
To Be Completed by Funeral Director	10e. Street and Number <i>6320 Ferryboat Circle</i>				10f. Zip Code <i>21044</i>	10g. Citizen of What Country? <i>U.S.A.</i>		
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: <i>Year</i>	13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. <i>WHITE</i>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>4</i>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>MANAGER</i>	16b. Kind of Business/Industry <i>FOOD SERVICE</i>				
	17. Father's Name (First, Middle, Last) <i>SAMUEL LEVIN</i>				18. Mother's Name (First, Middle, Maiden Surname) <i>GERTRUDE SAUL</i>			
	19a. Informant's Name/Relationship (Type, Print) <i>HAROLD BLYWEISS / HUSBAND</i>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>6320 FERRYBOAT CIRCLE - COLUMBIA, MD. 21044</i>					
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <i>COLUMBIA MEMORIAL PARK</i>		20b. Place of Disposition (Name of cemetery, crematory or other place) <i>COLUMBIA MEMORIAL PARK</i>		Date <i>04/15/2007</i>	20c. Location - City or Town, State <i>COLUMBIA, MD</i>		
	21. Signature of Funeral Service Licensee <i>Mark M. Cutts</i>		22. Name and Address of Facility <i>SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208</i>					
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <i>Intracerebral Bleed</i> Approximate Interval Between Onset and Death <i>one day</i>							
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <i>Chronic Myelogenous Leukemia</i> 17 years							
	a. Due to (or as a consequence of): <i>Intracerebral Bleed</i>							
	b. Due to (or as a consequence of): <i>Chronic Myelogenous Leukemia</i>							
	c. Due to (or as a consequence of): <i></i>							
	d. Due to (or as a consequence of): <i></i>							
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome pf pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <i>9 Unknown</i>			23d. Date of delivery Month <input type="checkbox"/> Day <input type="checkbox"/> Year		
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
	23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown							
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year) <i>M</i>		28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred <i></i>	
	28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) <i></i>		28f. Location (Street and Number or Rural Route Number, City or Town, State) <i></i>					
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
	29b. Signature and title of certifier <i>Mark King, M.D.</i>		29c. License number <i>Doc38026</i>			29d. Date signed (Month, Day, Year) <i>4/10/2007</i>		
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Mark King 5755 Cedar Lane Columbia Maryland</i>							
State Registrar	31. Date filed (Month, Day, Year) <i>APR 17 2007</i>		32. Registrar's Signature <i>James B. Apelle</i>					

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend 23a, per MD G866, 4/17/07 TT

State of Maryland Department of Health and Mental Hygiene

2007 12092

1- For State Registrar Amend #7&10d Per FH G866 4/16/07 Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last)				2. Date of Death Month Day Year	3. Time of Death
	ALLAN BLUMENTHAL				APRIL 9 2007	12:42 PM
Funeral Director	4a. Facility Name (If not institution, give street and number)			4b. City, Town, or Location of Death		4c. County of Death
	SINAI HOSPITAL			BALTIMORE		N/A
To Be Completed by Funeral Director	5. Social Security Number	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 61 62 Yrs.	If Under 1 Year Months Days Hours Min.	8. Date of Birth (Month, Day, Year) 11/06/1945	9. Birthplace (State or Foreign Country) OHIO
	Usual Residence of Decedent			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
10a. State MD			10b. County N/A		10c. City, Town or Location BALTIMORE	
10e. Street and Number 3601 FORDS LANE #512			10f. Zip Code 21215		10g. Citizen of What Country? U.S.A.	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 5+		16b. Kind of Business/Industry PSYCHOLOGIST		
17. Father's Name (First, Middle, Last) UNKNOWN			18. Mother's Name (First, Middle, Maiden Surname) BLUMENTHAL JULIA GREENWALD			
19a. Informant's Name/Relationship (Type, Print) JENNIFER MORRIS / FRIEND			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8806 PIKESVILLE ROAD - BALTIMORE, MD 21208			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input checked="" type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) MT. OLIVE CEMETERY		Date 04/15/2007	20c. Location - City or Town, State SOLON, OHIO
21. Signature of Funeral Service Licensee <i>Michael J. Singer</i>			22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Myocardial infarction Caused patient to die a. Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Approximate Interval Between Onset and Death One month to six months						
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last						
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						
23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown						
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA <input type="checkbox"/> Other <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.						
29b. Signature and title of certifier <i>Julian Jakobson</i>		29c. License number 025039		29d. Date signed (Month, Day, Year) 04/11/07		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Julian Jakobson 2835 Smith Ave Baltimore MD 21209		31. Date filed (Month, Day, Year) APR 16 2007				
32. Registrar's Signature <i>Julian Jakobson</i>						

Division of Vital Records, P.O. Box 68760,
23a
Patient Known as: ALLAN
Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified.

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2007

12092

1- For
State
Registrar

Physician
/Medical
Examiner

Funeral
Director

Baltimore, Maryland 21215-0036
Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.

To Be Completed by Funeral Director

1. Decedent's Name (First, Middle, Last) EARLE BOSWELL							2. Date of Death Month APRIL Day 13 Year 2007		3. Time of Death 10:55 A M	
4a. Facility Name (If not institution, give street and number) HOWARD COUNTY GENERAL				4b. City, Town, or Location of Death COLUMBIA				4c. County of Death HOWARD		
5. Social Security Number 214.12.0321		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 87 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	Hours	Min.	8. Date of Birth (Month, Day, Year) December 11, 1919		9. Birthplace (State or Foreign Country) Maryland
Usual Residence of Decedent 10a. State Maryland 10b. County Howard 10c. City, Town or Location Ellicott Cty								10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
10e. Street and Number 8449 Church Lane				10f. Zip Code 21043				10g. Citizen of What Country? U.S.A.		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Mechanic				16b. Kind of Business/Industry Automotive		
17. Father's Name (First, Middle, Last) Calvert Boswell					18. Mother's Name (First, Middle, Maiden Surname) Edna Tegeler					
19a. Informant's Name/Relationship (Type, Print) Ms. Dorothy Boswell Spouse				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8449 Church Lane Ellicott City, Maryland 21043						
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Good Shepherd Cemetery				Date 04/16/07	20c. Location - City or Town, State Ellicott City, Maryland	
21. Signature of Funeral Service Licensee <i>Dorothy Boswell</i>								22. Name and Address of Facility Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043		

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Approximate Interval Between Onset and Death

2 MONTHS

a. **COR PULMONALE**

Due to (or as a consequence of):

b. **CHRONIC OBSTRUCTIVE PULMONARY DISEASE**

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?
 Yes No
 Unknown

23c. If yes, outcome of pregnancy
 Live birth Fetal death Ectopic pregnancy
 Pregnant at time of death Other (specify) _____
 Unknown

23d. Date of delivery
Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

PULMONARY HYPERTENSION, PNEUMONIA, PULMONARY

EMBOLUS, DEEP VEIN THROMBOSIS, LEIDEN FACTOR 5

MUTATION, ANASARCA, CHRONIC KIDNEY DISEASE

23e. Did tobacco use contribute to the cause of death?

Yes No Probably Unknown

25. Was case referred to medical examiner?
 Yes No

26. Place of Death (Check only one)

Hospital: Inpatient ER/Outpatient DOA Other: Nursing Home Residence Other (Specify)

27. Manner of Death

Natural Pending investigation
 Accident Could not be determined
 Suicide Determined
 Homicide

28a. Date of Injury
(Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

28d. Describe how injury occurred

Yes No

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier
(Check only one)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

and manner stated.

29b. Signature and title of certifier

Joseph F. Gibbons, MD

29c. License number

J38296

29d. Date signed (Month, Day, Year)

APRIL 13, 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JOSEPH F. GIBBONS, MD 8156 LARK BROWN RD, SUITE 201, ELKRIDGE, MD 21075

31. Date filed (Month, Day, Year)

APR 17 2007

32. Registrar's Signature

Barbara B. Speller

10

Division or Vital Records, P.O. Box 68760,
To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial/transit
permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

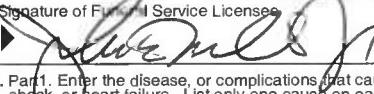
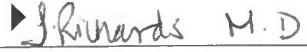
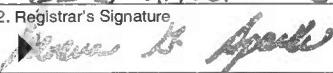
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2007 12091

1 - For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) SEAN, FERRIS, CARABINE							2. Date of Death Month 4 Day 13 Year 2007	3. Time of Death 19:30M	
	4a. Facility Name (If not institution, give street and number) UNIVERSITY OF MARYLAND HOSPITAL			4b. City, Town, or Location of Death BALTIMORE			4c. County of Death N/A			
Funeral Director	5. Social Security Number 129-56-4578	6. Sex 1 X M	7. Age (In yrs. last birthday) 35 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) March 29, 1972	9. Birthplace (State or Foreign Country) North Carolina			
To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State Maryland 10b. County Harford 10c. City, Town or Location Aberdeen 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No									
	10e. Street and Number 484 Elissa Court			10f. Zip Code 21001			10g. Citizen of What Country? USA			
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 years			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 4 years			16b. Kind of Business/Industry Computer Science Corp			
	17. Father's Name (First, Middle, Last) Brian Carabine			18. Mother's Name (First, Middle, Maiden Surname) Prudence Talmage - Hamilton						
	19a. Informant's Name/Relationship (Type, Print) Stephanie Carabine wife			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 484 Elissa Court, Aberdeen, Maryland 21001						
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Bayview Crematory			Date April 16, 2007	20c. Location - City or Town, State Baltimore, Maryland		
	21. Signature of Funeral Service Licensee 			22. Name and Address of Facility Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, Md. 21222						
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) MALIGNANT GLIONA								Approximate Interval Between Onset and Death	
	a. Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):									
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown			23c. If yes, outcome pf pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year			
Medical Certification: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		
								24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
								24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide			28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			28d. Describe how injury occurred			
				28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
	29b. Signature and title of certifier 			29c. License number 17457			29d. Date signed (Month, Day, Year) 4/13/2007			
Medical Certification: To Be Completed by Physician/Medical Examiner	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TANIQUE RICHARDS			31. Date filed (Month, Day, Year) APR 17 2007			32. Registrar's Signature 			

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
 Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2007 12095

Reg. No.

1- For State Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) EDWARD D. CARDER							2. Date of Death Month APRIL	Day 17, 2007	Year 2007	3. Time of Death 01:45 AM
	4a. Facility Name (If not institution, give street and number) JOHNS HOPKINS BAYVIEW MEDICAL CENTER			4b. City, Town, or Location of Death BALTIMORE			4c. County of Death				
Funeral Director	5. Social Security Number 212-24-0290	6. Sex 1 X M 2 F	7. Age (In yrs. last birthday) 76 Yrs.	If Under 1 Year Months 0	If Under 24 Hrs. Days 0	Hours 0	Min. 0	8. Date of Birth (Month, Day, Year) June 18, 1930	9. Birthplace (State or Foreign Country) West Virginia		
	Usual Residence of Decedent 10a. State Maryland			10b. County Baltimore					10c. City, Town or Location Dundalk		
10e. Street and Number 3169 Baybriar Road					10f. Zip Code 21222			10g. Citizen of What Country? USA			
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: 1950		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: White			14. Race - American Indian, Black, White, etc. Specify: White				
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 years		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Mechanic		16b. Kind of Business/Industry Post Office							
17. Father's Name (First, Middle, Last) James S. Carder					18. Mother's Name (First, Middle, Maiden Surname) Martha Hott						
19a. Informant's Name/Relationship (Type, Print) Henrietta Carder Wife			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3169 Baybriar Road, Dundalk, Md. 21222								
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Bayview Crematory			Date April 20, 2007		20c. Location - City or Town, State Dundalk, MD.			
21. Signature of Funeral Service Licensee 			22. Name and Address of Facility Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, Md. 21222								
23a. Part I Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) LUNG CANCER										Approximate Interval Between Onset and Death	
<p>a. Due to (or as a consequence of): LUNG CANCER</p> <p>b. Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. Due to (or as a consequence of):</p>											
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome pf pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year						
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)									
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) APRIL 17, 2007		28b. Time of Injury M 12:00 PM		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred			
28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)									
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No									
29b. Signature and title of certifier 		29c. License number RES-000			29d. Date signed (Month, Day, Year) APRIL 17, 2007						
31. Date filed (Month, Day, Year) APR 17 2007		32. Registrar's Signature 									

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit slip.

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
 Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2007 12096

Baltimore, Maryland 21215-0036

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or items 28a or 28e-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit slip.

State Registrar

Medical Certification: To Be Completed by Physician/Medical Examiner

1- For State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Glenn B. Crabill, Jr.							2. Date of Death Month Day Year April 12, 2007	3. Time of Death 8:30 A M
	4a. Facility Name (If not institution, give street and number) 1118 H. Spalding Drive			4b. City, Town, or Location of Death BEL AIR			4c. County of Death HARFORD		
Funeral Director	5. Social Security Number 219-42-0944	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 64 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) June 16, 1942	9. Birthplace (State or Foreign Country) MARYLAND		
	Usual Residence of Decedent Maryland		10c. City, Town or Location Bel Air			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
10a. State Maryland		10b. County Harford		10f. Zip Code 21014			10g. Citizen of What Country? U.S.A.		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: 12		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: White			14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Customer Service		16b. Kind of Business/Industry Trucking Company					
17. Father's Name (First, Middle, Last) Glenn B. Crabill, Sr.		18. Mother's Name (First, Middle, Maiden Surname) Ruby Morin							
19a. Informant's Name/Relationship (Type, Print) Patricia Crabill (Wife)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1118 H. Spalding Dr. Bel Air, MD 21014							
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) ► Stefanie Rineker		20b. Place of Disposition (Name of cemetery, crematory or other place) Harford Memorial		Date 04-16-2007	20c. Location - City or Town, State Bel Air, Maryland				
21. Signature of Funeral Service Licensee Stefanie Rineker		22. Name and Address of Facility Schimunek Funeral Home of Bel Air Inc. 610 W. MacPhail Rd. Bel Air, MD 21014							
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) CONGESTIVE HEART FAILURE		23b. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) CONGESTIVE HEART FAILURE		Approximate Interval Between Onset and Death					
23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year							
23e. Did tobacco use contribute to the cause of death? HYPERTENSION		23e. Did tobacco use contribute to the cause of death? DIABETES MELLITUS		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown					
24a. Was an autopsy performed? ► VIJAY M. ABHYANKAR MD		24b. Were autopsy findings available prior to completion of cause of death? ► VIJAY M. ABHYANKAR MD							
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA		Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) ► VIJAY M. ABHYANKAR MD					
27. Manner of Death ► Natural 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year) ► VIJAY M. ABHYANKAR MD		28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred			
5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) ► VIJAY M. ABHYANKAR MD		28f. Location (Street and Number or Rural Route Number, City or Town, State) ► VIJAY M. ABHYANKAR MD					
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29c. License number D25057		29d. Date signed (Month, Day, Year) APRIL 13 2007					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) VIJAY M. ABHYANKAR 2 NORTH AVE BEL AIR MD 21014		31. Date filed (Month, Day, Year) APR 17 2007		32. Registrar's Signature ► VIJAY M. ABHYANKAR MD					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

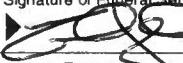
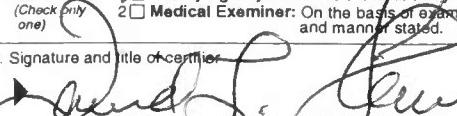
Certificate of Death

2007 12097

Reg. No.

1- For
State
Registrar

Physician
/Medical
Examiner

		1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year		3. Time of Death		
		Ariel O. Cambron-Lum		April 15, 2007		8:42pm M		
4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of Death		4c. County of Death				
Greater Baltimore Medical Center		Towson		Baltimore				
5. Social Security Number		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) Yrs. 95	If Under 1 Year Months Days Hours Min.	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Sept. 17, 1912	9. Birthplace (State or Foreign Country) MN	
Funeral Director		10a. State MD		10b. County Baltimore		10c. City, Town or Location Reisterstown		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
		10e. Street and Number 2106 Tufton Ridge Road		10f. Zip Code 21136		10g. Citizen of What Country? USA		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 4 Marketing Director		16b. Kind of Business/Industry US Treasury				
17. Father's Name (First, Middle, Last) Harley D. Oliver		18. Mother's Name (First, Middle, Maiden Surname) Martha Skjod						
19a. Informant's Name/Relationship (Type, Print) Russell Lum/Grandson		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2106 Tufton Ridge Road Reisterstown, MD 21136		20b. Place of Disposition (Name of cemetery, crematory or other place) Metro Crematory		Date April 17, 2007	20c. Location - City or Town, State Baltimore, MD	
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Lemmon Funeral Home of Dulaney Valley, Inc. Michael J. Flagle 10 W. Padonia Road Timonium, MD 21093						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		23b. Due to (or as a consequence of): Acute M.I.		23c. Approximate Interval Between Onset and Death 12 hrs				
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		b. Due to (or as a consequence of): ASPIRATION PNEUMONIA		12 hrs				
{		c. Due to (or as a consequence of): ORGANIC BRAIN SYNDROME		years				
d.								
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____ <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year				
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				23f. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? M <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred				
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29b. Signature and title of certifier 		29c. License number D22657		29d. Date signed (Month, Day, Year) 04/15/07				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DAVID STERN		GBMC - ER		6701 N. Charles St. Baltimore, MD 21204				
31. Date filed (Month, Day, Year) APR 17 2007		32. Registrar's Signature 		ORIGINAL				

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 12098

1- For State Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) VIRGINIA CLARK				2. Date of Death Month Day Year APRIL 15 2007	3. Time of Death 10:30 AM		
	4a. Facility Name (If not institution, give street and number) BALTIMORE WASHINGTON MED CTR		4b. City, Town, or Location of Death GLEN BURNIE		4c. County of Death ANNE ARUNDEL			
Funeral Director	5. Social Security Number 212-58-7997	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 85 Yrs.	If Under 1 Year Months Days Hours Min.	8. Date of Birth (Month, Day, Year) Oct. 28, 1921	9. Birthplace (State or Foreign Country) MD		
	Usual Residence of Decedent 10a. State MD		10b. County Anne Arundel		10c. City, Town or Location Linthicum		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
To Be Completed by Funeral Director	10e. Street and Number 617 Forest View Road			10f. Zip Code 21090		10g. Citizen of What Country? U.S.A.		
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Home Maker		16b. Kind of Business/Industry Home Owner			
	17. Father's Name (First, Middle, Last) Calvin Thomas Gaither			18. Mother's Name (First, Middle, Maiden Surname) Goldie Irene Griffith				
	19a. Informant's Name/Relationship (Type. Print) Mrs. Sharon Gibbs /Niece			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 204 4th Avenue SE Glen Burnie, MD 21061				
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) Selma Shire m01479		20b. Place of Disposition (Name of cemetery, crematory or other place) Glen Haven Mem. Park		Date April 18, 2007	20c. Location - City or Town, State Glen Burnie, MD		
	21. Signature of Funeral Service Licensee Selma Shire m01479		22. Name and Address of Facility Singleton Funeral Home, P.A. 1 Second Avenue SW Glen Burnie, MD 21061					
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) b. ACUTE MYOCARDIAL INFARCTION Due to (or as a consequence of): c. PERIPHERAL VASCULAR DISEASE Due to (or as a consequence of): d. _____ Approximate Interval Between Onset and Death DAYS							
Medical Certification: To Be Completed by Physician/Medical Examiner	23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown 23c. If yes, outcome pf pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) _____ 9 <input type="checkbox"/> Unknown 23d. Date of delivery Month Day Year							
	23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown							
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No							
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No							
	26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Homicide 28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 28d. Describe how injury occurred							
	28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)							
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
	29b. Signature and title of certifier George Baffoe-Bonuwe, MD							
	29c. License number DO059190							
	29d. Date signed (Month, Day, Year) APRIL 15 2007							
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GEORGE BAFFOE-BONUWE							
	31. Date filed (Month, Day, Year) APR 17 2007							
	32. Registrar's Signature James B. Gaffey							

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division or Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 12099

1- For State Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Helen F. Christopher							2. Date of Death Month April Day 11 Year 2007	3. Time of Death 7:35A M	
	4a. Facility Name (If not institution, give street and number) Dove House				4b. City, Town, or Location of Death Westminster			4c. County of Death Carroll		
Funeral Director	5. Social Security Number 213-14-3691	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 92 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Hours	8. Date of Birth (Month, Day, Year) Aug. 1, 1914	9. Birthplace (State or Foreign Country) MD			
Usual Residence of Decedent 10a. State MD 10b. County Baltimore 10c. City, Town or Location Owings Mills 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										
10e. Street and Number 119 Byway Road				10f. Zip Code 21117			10g. Citizen of What Country? USA			
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: White			14. Race - American Indian, Black, White, etc. Specify:		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 9				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Cashier			16b. Kind of Business/Industry School Cafeteria			
17. Father's Name (First, Middle, Last) Anthony Hudy					18. Mother's Name (First, Middle, Maiden Surname) Frances Szumilo					
19a. Informant's Name/Relationship (Type, Print) William Christopher Son				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 413 Monterey Dr. Westminster, MD 21157						
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) Eline				20b. Place of Disposition (Name of cemetery, crematory or other place) Lake View Mem. Park			Date 4/14/07	20c. Location - City or Town, State Sykesville, MD		
21. Signature of Funeral Service Licensee Eline				22. Name and Address of Facility ELINE FUNERAL HOME Reisterstown, MD 21136						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Primary Tonsillar Cancer Due to (or as a consequence of): b. _____ Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____ Approximate Interval Between Onset and Death: 6 months										
23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown				23c. If yes, outcome pf pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____ <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown										
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) Hospital						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide				28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred		
				28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier Dr. Ernesto Mendoza						
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Ernesto Mendoza				32. Registrar's Signature Steve B. Spates			29c. License number 00050763			29d. Date signed (Month, Day, Year) 4/12/07
31. Date filed (Month, Day, Year) APR 17 2007				32. Registrar's Signature						

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

5
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 12100

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Catherine M. Cromwell					2. Date of Death Month APRIL Day 11 , Year 2007	3. Time of Death 6:55A M				
	4a. Facility Name (If not institution, give street and number) Saint Joseph Medical Center		4b. City, Town, or Location of Death Towson			4c. County of Death Baltimore					
Funeral Director	5. Social Security Number 220-20-5822	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 80 Yrs.	If Under 1 Year Months <input type="checkbox"/> Days <input type="checkbox"/>	If Under 24 Hrs. Hours <input type="checkbox"/> Min. <input type="checkbox"/>	8. Date of Birth (Month, Day, Year) July 6, 1926	9. Birthplace (State or Foreign Country) Maryland				
To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State Md. 10b. County Baltimore		10c. City, Town or Location Towson				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
	10e. Street and Number 409 Virginia Avenue			10f. Zip Code 21286		10g. Citizen of What Country? USA					
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: 1942		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: White			14. Race - American Indian, Black, White, etc.				
	15. Decedent' Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Homemaker		16b. Kind of Business/Industry Own Home							
	17. Father's Name (First, Middle, Last) Charles Maenner			18. Mother's Name (First, Middle, Maiden Surname) Margaruete Deal							
	19a. Informant's Name/Relationship (Type, Print) Stephen C. Cromwell, Sr./Son			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 827 Kellogg Road Timonium, Maryland 21093							
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) St. Mary's Govans Cem.		20b. Place of Disposition (Name of cemetery, crematory or other place) St. Mary's Govans Cem.		Date 4/14/07	20c. Location - City or Town, State Baltimore, Maryland					
	21. Signature of Funeral Service Licensee ► Michael J. Ruck		22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Maryland 21204								
Physician /Medical Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) CHRONIC OBSTRUCTIVE PULMONARY DISEASE Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. _____							Approximate Interval Between Onset and Death			
	23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown							23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown	23d. Date of delivery Month Day Year		
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. HYPOTENSION SPINAL STENOSIS MULTIPLE COMPRESSION FRACTURE OF SPINE							23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide							28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred
	28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)							28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							29b. Signature and title of certifier ► K. Poh Lim, M.D.			
	29c. License number D37254							29d. Date signed (Month, Day, Year) 4/11/07			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BOON POH LIM, M.D. 7601 OSLER DRIVE TOWSON, MARYLAND 21204										
	31. Date filed (Month, Day, Year) APRIL 17 2007		32. Registrar's Signature ► K. Poh Lim								

Division or Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
 Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2007 12101

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) MYRTLE ELLEN COWAN						2. Date of Death Month 04 Day 11 Year 2007	3. Time of Death 6:10 AM		
	4a. Facility Name (If not institution, give street and number) THE MILLENIUM OF FORESTVILLE			4b. City, Town, or Location of Death FORESTVILLE			4c. County of Death PRINCE GEORGES			
Funeral Director	5. Social Security Number 218 16 0684	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 88 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) 01-01-1919	9. Birthplace (State or Foreign Country) WASHINGTON, DC			
	Usual Residence of Decedent 10a. State MD 10b. County PRINCE GEORGES			10c. City, Town or Location CAPITOL HEIGHTS			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
To Be Completed by Funeral Director	10e. Street and Number 505 SUFFOLK AVENUE			10f. Zip Code 20743			10g. Citizen of What Country? USA			
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: WHITE		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) COLLEGE		16b. Kind of Business/Industry HOUSEWIFE			16c. Kind of Business/Industry PRIVATE		
	17. Father's Name (First, Middle, Last) WILLIAM CHANEY				18. Mother's Name (First, Middle, Maiden Surname) MINNIE UNKNOWN					
	19a. Informant's Name/Relationship (Type, Print) LINDA MAXWELL/FRIEND				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2415 LYNDON STREET, ADELPHI, MD 20783					
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) METROPOLITAN CREMATORIAL 4-12-07			20c. Location - City or Town, State ALEXANDRIA, VA				
	21. Signature of Funeral Service Licensee 		22. Name and Address of Funeral Home MARSHALL'S FUNERAL HOME OF MD, INC. 4308 SUITLAND RD, SUITLAND, MD 20746							
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death	
	<p>a. CARDIOPULMONARY FAILURE Due to (or as a consequence of):</p> <p>b. HYPERTENSIVE CARDIOVASCULAR DISEASE Due to (or as a consequence of):</p> <p>c. HYPERTENSION Due to (or as a consequence of):</p> <p>d. _____</p>									
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____ <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year				
Medical Certification: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DEMENTIA								23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
									24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred				
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)				
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29c. License number D51520			29d. Date signed (Month, Day, Year) 4-11-07				
	29b. Signature and title of certifier 									
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BAHRAM PISHDAD, MD, 1328 SOUTHERN AVE SE, WASHINGTON, DC 20032									
State Registrar	31. Date filed (Month, Day, Year) APR 17 2007		32. Registrar's Signature 							

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

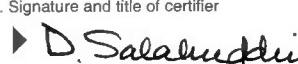
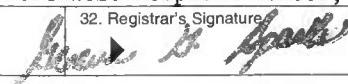
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or items 23a or 28a show any injury or other traumatic event, the Medical Examiner must be notified.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Amend #16b, 19b, 30, per FH, DVR, g866, 4/16/07 TT Certificate of Death

Reg. No. 2007 12102

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) ESTHER S. CLASSON				2. Date of Death Month 4 Day 12 Year 07	3. Time of Death 1555^M
	4a. Facility Name (If not institution, give street and number) NORTHWEST HOSPITAL CENTER RANDALLSTOWN		4b. City, Town, or Location of Death BALTIMORE		4c. County of Death BALTIMORE	
Funeral Director	5. Social Security Number 218-22-0687	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 89 Yrs.	If Under 1 Year Months 0 Days 0 Hours 0 Min. 0	8. Date of Birth (Month, Day, Year) 5/11/1917	9. Birthplace (State or Foreign Country) NY
To Be Completed by Funeral Director	10a. State MD 10b. County BALTIMORE 10c. City, Town or Location OWINGS MILLS				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	10e. Street and Number 4730 ATRIUM COURT #178			10f. Zip Code 21117	10g. Citizen of What Country? U.S.A.	
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) SECRETARY		16b. Kind of Business/Industry Government US GOVERNMENT	
	17. Father's Name (First, Middle, Last) SAMUEL			18. Mother's Name (First, Middle, Maiden Surname) STEIN ROSE DECKELBAUM		
	19a. Informant's Name/Relationship (Type, Print) ROBERT CLASSON / SON			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 210 TOCKWOGH DRIVE - EARLVILLE, MD 21919		
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory, or other place) OHEB SHALOM MEMORIAL PARK		Date 04/15/2007	20c. Location - City or Town, State REISTERSTOWN, MD
	21. Signature of Funeral Service Licensee 			22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208		
Physician /Medical Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last					
	<p>a. Dementia Due to (or as a consequence of):</p> <p>b. Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. Due to (or as a consequence of):</p>					
	Approximate Interval Between Onset and Death					
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown					
	23c. If yes, outcome pf pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown <input type="checkbox"/> Other (specify) _____					
	23d. Date of delivery Month Day Year					
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Chronic Atrial Fibrillation Ischemic Heart Disease					
	23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown					
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
	26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide					
	28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
	28d. Describe how injury occurred					
	28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)					
	28f. Location (Street and Number or Rural Route Number, City or Town, State)					
	29a. Certifier <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
	29b. Signature and title of certifier 					
	29c. License number D20252					
	29d. Date signed (Month, Day, Year) 4/12/07					
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dalilah K. Salahuddin, Northwest Hospital Center, Randallstown, MD					
Medical Certification: To Be Completed by Physician/Medical Examiner	31. Date filed (Month, Day, Year) APR 17 2007					
	32. Registrar's Signature 					

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

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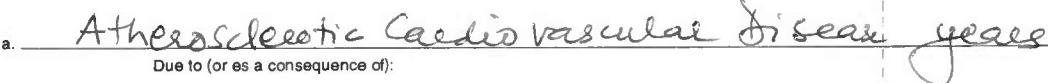
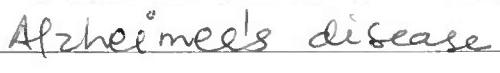
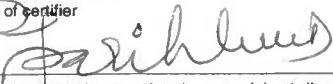
State Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 12103

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) EDWARD HARRY COPPEL						2. Date of Death Month APRIL Day 12 Year 2007	3. Time of Death 12:01 AM	
	4a Facility Name (If not institution, give street and number) FUTURE CARE OLD COURT			4b. City, Town, or Location of Death RANDALLSTOWN			4c. County of Death BALTIMORE		
Funeral Director	5. Social Security Number 217-16-6853	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 95 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days Hours Min.	8. Date of Birth (Month, Day, Year) 08/12/1911	9. Birthplace (State or Foreign Country) ILLINOIS		
To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State MD 10b. County BALTIMORE 10c. City, Town or Location RANDALLSTOWN						10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No X		
	10e. Street and Number 5 SHERATON ROAD			10f. Zip Code 21133			10g. Citizen of What Country? U.S.A.		
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12			16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) INTER OFFICE COURIER			16b. Kind of Business/Industry MARYLAND DEPARTMENT OF MOTOR VEHICLES		
	17. Father's Name (First, Middle, Last) MAURICE			18. Mother's Name (First, Middle, Maiden Surname) COPPEL EVA LEVIN					
	19a. Informant's Name/Relationship (Type, Print) MIMI BILLER / NIECE			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5 SHERATON ROAD - RANDALLSTOWN, MD 21133					
Physician /Medical Examiner	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) BNAI ISRAEL CONG.			Date 20c. Location - City or Town, State 04/15/2007 BALTIMORE, MD		
	21. Signature of Funeral Service Licensee 			22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a.  Due to (or as a consequence of):						Approximate Interval Between Onset and Death		
	b. Due to (or as a consequence of):								
	c. Due to (or as a consequence of):								
	d. Due to (or as a consequence of):								
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
							24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide			28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred		
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)		
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
	29b. Signature and title of certifier 			29c. License number D32158			29d. Date signed (Month, Day, Year) 4/12/07		
	30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Jyoti Patel, MD 576 N. Rolling Rd, Ste 108, Catonsville MD 21228								
	31. Date filed (Month, Day, Year) APR 17 2007			32. Registrar's Signature 					

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-trust certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23e show any injury or other traumatic event, the Medical Examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2007 12104

1- For State
Registrar

Physician/ Medical Examiner	1. Decedent's Name (First, Middle, Last) Nevolia O Duvall					2. Date of Death Month Day Year March 28, 2007	3. Time of Death 1620 hrs	
	4a. Facility Name (if not institution, give street and number) Woods behind 3116 Persimmon Treet Court			4b. City, Town, or Location of Death Woodstock		4c. County of Death Baltimore County		
Funeral Director	5. Social Security Number 212-22-3759	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 83 Yrs.	If Under 1 Year Months Days Hours Min. 05 29 23	8. Date of Birth (MM/DD/YYYY) 05 29 23	9. Birthplace (State or Foreign Country) VA		
	Usual Residence of Decedent 10a. State MD 10b. County NA 10c. City, Town or Location Baltimore						10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
To Be Completed by Funeral Director	10e. Street and Number 2609 Spelman Road			10f. Zip Code 21225		10g. Citizen of What Country? U.S.A.		
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No specify: Black		14. Race - American Indian, Black, White, etc. Specify: Black	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th grade			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) na Domestic		16b. Kind of Business/Industry Private		
	17. Father's Name (First, Middle, Last) James Johnson			18. Mother's Name (First, Middle, Maiden Surname) Rebecca Jones				
	19a. Informant's Name/Relationship (Type, Print) Wendell Jones Sr.-Grandson			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1426 Pleasant Valley Dr., Catonsville, Md 21228				
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other Specify:			20b. Place of Disposition (Name of cemetery, crematory or other place) Arbutus Memorial	Date 4/21/07	20c. Location - City or Town, State Arbutus, Md		
Physician /Medical Examiner	21. Signature of Funeral Service Licensee Sonette K. Jones			22. Name and Address of Facility March F/H West 1300 Wabash Ave, Baltimore, Md 21215				
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. No Identifiable Anatomic Abnormality Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. <input type="checkbox"/> UNPENDED <input type="checkbox"/> AMENDED						Approximate Interval Between Onset and Death	
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown			23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Dementia			23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown			23f. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	23g. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No
	25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other: Scene					
	27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 6 <input checked="" type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year) FOUND: Mar 28, 2007	28b. Time of Injury FOUND: 1615 hrs	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	28d. Describe how injury occurred Unknown		
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Woods		28f. Location (Street and Number or Rural Route Number, City or Town, State) 3116 Persimmon Tree Court, Woodstock, MD					
	29a. Certifier 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) March 29, 2007			
	30. Name and address of person who completed cause of death (Item 23a) Carol Allan, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201		31. Date filed (Month, Day, Year) APR 17 2007 32. Registrar's Signature Jane K. Jones					

Baltimore, MD 21215-0036

Important: If item 27 is marked other than "natural", or items 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Division of Vital Records, P.O. Box 68760,
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit

Medical Certification: To Be Completed by Physician/Medical Examiner**State
Registrar**

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2007 12105

Reg. No.

1- For State
Registrar**Physician/
Medical Examiner**1. Decedent's Name (First, Middle, Last) **Michael Francis Dunnigan Dunnigan**
Michael F. Dunnigan2. Date of Death
Month Day Year
April 15, 20073. Time of Death
1750 hrs**Funeral
Director**4a. Facility Name (if not institution, give street and number)
Union Memorial Hospital4b. City, Town, or Location of Death
Baltimore

4c. County of Death

5. Social Security Number
219-42-74996. Sex
XXM7. Age (In yrs. last birthday)
628. If Under 1 Year
Months Days Hours Min.

Yrs.

9. Date of Birth (MM/DD/YYYY)
2/26/194510. Birthplace (State or
Foreign Country)
MD

Usual Residence of Decedent

10a. State
MD10b. County
N/A10c. City, Town or Location
Baltimore10d. Inside City Limits
1 X Yes 2 No10e. Street and Number
1321 Clipper Heights Avenue10f. Zip Code
2121110g. Citizen of What Country?
USA11. Marital Status
1 Never Married 2 Married3 Widowed 4 Divorced12. Was Decedent Ever in U.S.
Armed Forces?If Yes, Give Year
or Dates
Vietnam13. Was Decedent of Hispanic Origin? (Specify Yes or No)
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 Yes 2 No specify14. Race - American Indian, Black,
White, etc.
white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done
during most of working life. DO NOT use retired)

Iron worker

16b. Kind of Business/Industry
Restoration17. Father's Name (First, Middle, Last)
James V. Dunnigan18. Mother's Name (First, Middle, Maiden Surname)
Vera J. Gregory19a. Informant's Name/Relationship (Type, Print)
Vera Dunnigan Mother19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
2205 Byrnes Ct. Belair, MD 2101520a. Method of Disposition
1 Burial 2 Cremation 3 Removal from State4 Donation 5 Other Specify21. Signatures of Funeral Service Licensee
Jean H. Carpenter22. Name and Address of Facility
Burgee-Henss-Seitz Funeral Home, Inc.

3631 Falls Road Baltimore, MD 21211

23a. Part I Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. **Acute blood loss complicating lung disease**
Due to (or as a consequence of):b. _____
Due to (or as a consequence of):c. _____
Due to (or as a consequence of):

d. _____

X UNPENDED X AMENDED #1, perME, g868, 6/26/07 TT
#3, perFH, G66, 4/19/07 TT // #1,23a,27,perME, g868, 6/25/07 TTIF FEMALE:
23b. Was decedent pregnant in the past 12 months?1 Yes 2 No 9 Unknown23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 3 Ectopic pregnancy4 Pregnant at time of death 5 Other (Specify)9 Unknown23d. Date of delivery
Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?
1 Yes 2 No 3 Probably 4 Unknown24a. Was an autopsy performed?
1 Yes 2 No24b. Were autopsy findings available prior to completion of cause of death?
1 Yes 2 No25. Was case referred to medical examiner?
1 Yes 2 NoHospital: 1 Inpatient 2 ER/Outpatient 3 DOAOther 4 Nursing Home 5 Residence 6 Other

26. Place of Death (Check only one)

27. Manner of Death
1 Natural 5 Pending Investigation2 Accident 6 Could not be determined3 Suicide 7 Determined4 Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 Yes 2 No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc.

(Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier
(Check only one)
1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

and manner stated.

29b. Signature and title of certifier
Tasha Greenberg MD

Assistant Medical Examiner

111 Penn Street, Baltimore, MD 21201

29c. License number
O.C.M.E.29d. Date signed (Month, Day, Year)
April 16, 200731. Date filed (Month, Day, Year)
APR 17 200732. Registrar's Signature
Janet H. Carpenter

ORIGINAL

Baltimore, MD 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed

within 24 hours after death
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Permit Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene
Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.State
RegistrarDHMH 17 Rev 1/2001
O CME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#10C, d, 1, 10b, 17, 20a, 22, PERFH, G867, 5/17/07, WS

State of Maryland / Department of Health and Mental Hygiene

amend item 10e per fh g867 5-2-07 yr

Certificate of Death

Reg. No.

2007 12106

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last)							2. Date of Death Month Day Year	3. Time of Death	
	Ernest Dunlap							April 9, 2007	4:03 AM M	
Funeral Director	4a. Facility Name (If not institution, give street and number)			4b. City, Town, or Location of Death			4c. County of Death			
	Prince George's Medical Center			Cheverly			Prince George's			
	5. Social Security Number	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 72 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) Aug 12, 1934	9. Birthplace (State or Foreign Country) South Carolina			
	Usual Residence of Decedent									
	10a. State MD	10b. County Prince George's	10c. City, Town or Location Bowie Large					10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
	10e. Street and Number 705 James Ridge Rd. 500 Large Road			10f. Zip Code 20721 20774			10g. Citizen of What Country? USA			
	11. Marital Status 1 <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: black			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 0 cook				16b. Kind of Business/Industry Restaurant		
	17. Father's Name (First, Middle, Last) George Dunlap Paul Williams				18. Mother's Name (First, Middle, Maiden Surname) Willora White					
	19a. Informant's Name/Relationship (Type, Print) Ernestine Dunlap/spouse				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 705 James Ridge Road Bowie, MD 20721					
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input checked="" type="checkbox"/> Other (Specify) in state				20b. Place of Disposition (Name of cemetery, crematory or other place) Chesapeake Crematory		Date 5/2/07	20c. Location - City or Town, State Beltsville, MD		
	21. Signature of Funeral Service Licensee Donald S. Wade, Director				22. Name and Address of Facility Going Home Cremation Service P.O. Box 704 Clarksville, MD 21029		Baltimore, MD 21201			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.								Approximate Interval Between Onset and Death	
	Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of): fatal cardiac arrhythmia									
	b. Due to (or as a consequence of): respiratory distress									
	c. Due to (or as a consequence of):									
	d. _____									
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) _____ 9 <input type="checkbox"/> Unknown						23d. Date of delivery Month Day Year	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown	
									24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
									24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)	
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide								28a. Date of Injury (Month, Day, Year) 28b. Time of Injury M 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 28d. Describe how injury occurred	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)								28f. Location (Street and Number or Rural Route Number, City or Town, State)	
	29a. Certifier 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								29b. Signature and title of certifier  29c. License number D58182	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Donald George 3001 Hospital Drive Cheverly MD 20785								29d. Date signed (Month, Day, Year) 4-10-07	
	31. Date filed (Month, Day, Year) APR 17 2007								32. Registrar's Signature 	

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
 Department: If Item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified all once.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2007 12107

Reg. No.

1- For
State
Registrar

Physician
/Medical
Examiner

Funeral
Director

To Be Completed by Funeral Director

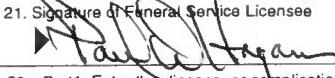
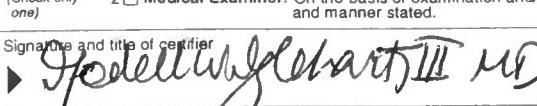
Baltimore, Maryland 21215-0036

Permit Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 28a or 28a-1 show any injury or other traumatic event, the Medical Examiner, if used, shall fill in all

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached or used as the burial/transit

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month Day Year			3. Time of Death		
Francis Markoe Dugan			April 12, 2007			11:15 AM		
4a. Facility Name (If not institution, give street and number)			4b. City, Town, or Location of Death			4c. County of Death		
1055 West Joppa Road, Apt. 746			Towson			Baltimore		
5. Social Security Number		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 89 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Hours	8. Date of Birth (Month, Day, Year) Nov. 28, 1917	9. Birthplace (State or Foreign Country) Maryland	
Usual Residence of Decedent						10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
10a. State Maryland	10b. County Baltimore	10c. City, Town or Location Towson						
10e. Street and Number 1055 West Joppa Road, Apt. 746			10f. Zip Code 21204			10g. Citizen of What Country? U.S.A.		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No WW II If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Physician			16b. Kind of Business/Industry Medicine			
17. Father's Name (First, Middle, Last) Hammond James Dugan			18. Mother's Name (First, Middle, Maiden Surname) Agnes Barry Markoe					
19a. Informant's Name/Relationship (Type, Print) Elizabeth Dugan Wife			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1055 West Joppa Road, Apt 746 Towson, Maryland 21204			Date		
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Hilltop Service Corp.			20c. Location - City or Town, State Towson Maryland		
21. Signature of Funeral Service Licensee 			22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Maryland 21204					
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Congestive Heart Failure								
Approximate Interval Between Onset and Death 6 mo								
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								
23b. Due to (or as a consequence of): a. Congestive Heart Failure								
b. Due to (or as a consequence of):								
c. Due to (or as a consequence of):								
d. Due to (or as a consequence of):								
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify)			23d. Date of delivery Month Day Year			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Aortic stenosis								
23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown								
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred		
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Iredell W Iglenart III MD								
29b. Signature and title of certifier 			29c. License number D33400			29d. Date signed (Month, Day, Year) 04/13/2007		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Iredell W Iglenart III MD 630 N Charles St Baltimore, MD 21212								
31. Date filed (Month, Day, Year) APR 17 2007		32. Registrar's Signature 						

State
Registrar

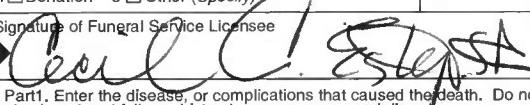
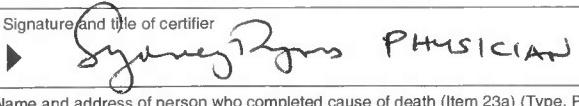
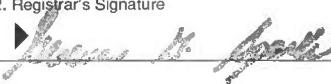
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 12108

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Leonard Davis					2. Date of Death Month Day Year Apr 13, 2007	3. Time of Death 5:15 a M		
	4a. Facility Name (If not institution, give street and number) 1500 North Spring Street			4b. City, Town, or Location of Death Baltimore		4c. County of Death N/A			
Funeral Director	5. Social Security Number 214-62-7636		6. Sex 1 X Male 2 F	7. Age (In yrs. last birthday) 53 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Sep 11, 1953	9. Birthplace (State or Foreign Country) Maryland	
	Usual Residence of Decedent Maryland		10a. State Maryland 10b. County N/A		10c. City, Town or Location Baltimore			10d. Inside City Limits 1 X Yes 2 No	
To Be Completed by Funeral Director	10e. Street and Number 1500 North Spring Street			10f. Zip Code 21213		10g. Citizen of What Country? U.S.A.			
	11. Marital Status 1 X Never Married 2 Married 3 Widowed 4 Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 X No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 X Yes 2 X No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Teacher		16b. Kind of Business/Industry Baltimore City Public Schools				
	17. Father's Name (First, Middle, Last) Joseph Davis			18. Mother's Name (First, Middle, Maiden Surname) Essie Davis					
	19a. Informant's Name/Relationship (Type, Print) Emma Patterson Sister			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3922 Duvall Avenue Baltimore, Maryland 21216					
	20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Mt. Zion Cemetery		Date 04/18/07	20c. Location - City or Town, State Lansdowne, Maryland			
	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Estep Brothers Funeral Service, P. A. 1300 Eutaw Place Baltimore, Md 21217						
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Gastric cancer Approximate Interval Between Onset and Death 3 months								
	a. Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):								
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 X Yes 2 No 9 Unknown		23c. If yes, outcome pf pregnancy 1 X Live birth 2 Fetal death 3 X Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown				23d. Date of delivery Month Day Year		
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								
	23e. Did tobacco use contribute to the cause of death? 1 X Yes 2 X No 3 Probably 4 Unknown								
	23f. Did alcohol contribute to the cause of death? 1 X Yes 2 X No 3 Probably 4 Unknown								
	25. Was case referred to medical examiner? 1 X Yes 2 X No		26. Place of Death (Check only one) Hospital: 1 X Inpatient 2 ER/Outpatient 3 X DOA Other: 4 X Nursing Home 5 X Residence 6 X Other (Specify)						
	27. Manner of Death 1 X Natural 5 X Pending investigation 2 X Accident 6 X Could not be determined 3 X Suicide 4 X Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	28c. Injury at Work? 1 X Yes 2 X No	28d. Describe how injury occurred		
			28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
	29a. Certifier (Check only one) 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 X Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
	29b. Signature and title of certifier 		29c. License number D53590		29d. Date signed (Month, Day, Year) APRIL 13, 2007				
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SYDNEY DY MD Room 609		624 N Broadway BALTIMORE MD 21205						
State Registrar	31. Date filed (Month, Day, Year) APR 17 2007		32. Registrar's Signature 						

Baltimore, Maryland 21215-0036
 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
 Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Medical Certification: To Be Completed by Physician/Medical Examiner

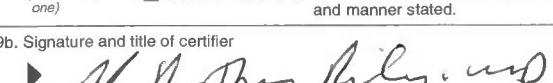
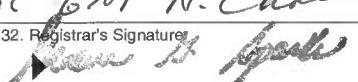
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
amend items 8, 10e per fh s866 4-25-07 yr

State of Maryland / Department of Health and Mental Hygiene

1 - For
State
Registrar

Certificate of Death

Reg. No. 2007 12109

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last)				2. Date of Death Month Day Year	3. Time of Death		
	Elizabeth A. Durning				April 11, 2007		11:05 p.m.	
Funeral Director	4a. Facility Name (If not institution, give street and number) Gilchrist Hospice Center			4b. City, Town, or Location of Death Towson		4c. County of Death Baltimore		
	5. Social Security Number 149-22-1335	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 77 Yrs.	If Under 1 Year Months Days Hours Min.	8. Date of Birth (Month, Day, Year) July 23, 1929	9. Birthplace (State or Foreign Country) New York		
To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State Maryland 10b. County Baltimore 10c. City, Town or Location Baltimore				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
	10e. Street and Number 960 Fell St. #409			10f. Zip Code 21231	10g. Citizen of What Country? U.S.A.			
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Investigator		16b. Kind of Business/Industry Telephone Company			
	17. Father's Name (First, Middle, Last) John Mason			18. Mother's Name (First, Middle, Maiden Surname) Adelaide Mackey				
	19a. Informant's Name/Relationship (Type, Print) Ms. Mary Durning Daughter		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2708 Rocky Glen Way Ellicott City, Maryland 21043					
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Bayview Crematory		Date 04/13/07	20c. Location - City or Town, State Baltimore, MD		
	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043					
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure! List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Lung Cancer						Approximate Interval Between Onset and Death months	
	<p>a. Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):</p>							
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome pf pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown				23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23e. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
							24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) Hospice					
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred		
			28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)		
	29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
	29b. Signature and title of certifier 		29c. License number D25205			29d. Date signed (Month, Day, Year) April 12, 2007		
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) W. A. Riley G BMC 6701 N. Charles St. Balt. MD 21202							
State Registrar	31. Date filed (Month, Day, Year) APR 17 2007		32. Registrar's Signature 					

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 12110

1- For State Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) MARGARET G. DRANSFIELD					2. Date of Death Month 04 Day 10 Year 2007 06:00 AM	3. Time of Death		
	4a. Facility Name (If not institution, give street and number) 2434 W. Belvedere Ave. Levindale		4b. City, Town, or Location of Death Baltimore			4c. County of Death N/A			
Funeral Director	5. Social Security Number 161-05-5631	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 92 Yrs.	If Under 1 Year Months 0	If Under 24 Hrs. Days 0	8. Date of Birth (Month, Day, Year) Sept. 8, 1914	9. Birthplace (State or Foreign Country) Pennsylvania		
To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State Maryland 10b. County N/A 10c. City, Town or Location Baltimore						10d. Inside City Limits <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		
	10e. Street and Number 2434 W. Belvedere Ave Levindale			10f. Zip Code 21215		10g. Citizen of What Country? USA			
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 5		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker			16b. Kind of Business/Industry Own Home			
	17. Father's Name (First, Middle, Last) Martin Cain				18. Mother's Name (First, Middle, Maiden Surname) Sarah Purcell				
	19a. Informant's Name/Relationship (Type, Print) Margaret L. Kick Daughter			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1616 Alston Road, Towson, Maryland 21204					
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Gardens of Faith			Date 4/16/2007	20c. Location - City or Town, State Fullerton, Maryland		
	21. Signature of Funeral Service Licensee Dawn B. Henss			22. Name and Address of Facility Burgee-Henss-Seitz Funeral Home, Inc. 21211 3631 Falls Road, Baltimore, Maryland					
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)						Approximate Interval Between Onset and Death		
	TERMINAL DEMENTIA								
	<p>a. Due to (or as a consequence of): </p> <p>b. Due to (or as a consequence of): </p> <p>c. Due to (or as a consequence of): </p> <p>d. Due to (or as a consequence of): </p>								
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome pf pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 9 <input type="checkbox"/> Unknown 5 <input type="checkbox"/> Other (specify) _____			23d. Date of delivery Month Day Year			
Medical Certification: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown		
							24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
							24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred			
			28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 			28f. Location (Street and Number or Rural Route Number, City or Town, State) 			
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
	29b. Signature and title of certifier Dawn B. Henss MD		29c. License number D0064533			29d. Date signed (Month, Day, Year) 04/10/2007			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BABATUNDE M-ASANI MD		LEVINDALE - HEBREW GERIATRIC CENTER 2434 W. BELVEDERE AVE - BALTIMORE, MD 21215						
State Registrar	31. Date filed (Month, Day, Year) APR 17 2007		32. Registrar's Signature Dawn B. Henss						

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural"; or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 12111

1- For State Registrar

Physician /Medical Examiner

Funeral Director

To Be Completed by Funeral Director

1. Decedent's Name (First, Middle, Last) EUGENE ROLAND EDMONSTON		2. Date of Death Month 04 Day 13 Year 2007		3. Time of Death 21:00PM
4a. Facility Name (If not institution, give street and number) CARROLL HOSPITAL CENTER		4b. City, Town, or Location of Death WESTMINSTER		4c. County of Death CARROLL
5. Social Security Number 216-14-7309		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 85 Yrs.	If Under 1 Year Months 0 Days 0 Hours 0 Min. 0
10a. State MD		10b. County Carroll	10c. City, Town or Location Sykesville	
10e. Street and Number 6905 Sheffield Drive			10f. Zip Code 21784	10g. Citizen of What Country? USA
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: WWII	13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: white	14. Race - American Indian, Black, White, etc. Specify: white
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) salesman		16b. Kind of Business/Industry carpet/furniture
17. Father's Name (First, Middle, Last) Marshall Edmonston			18. Mother's Name (First, Middle, Maiden Surname) Grace Grempler	
19a. Informant's Name/Relationship (Type, Print) William B. Edmonston (son)			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 825 Windy Knoll, Sykesville, MD 21784	
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) 12		20b. Place of Disposition (Name of cemetery, crematory or other place) All County Cremation	Date 4-16-07	20c. Location - City or Town, State Sykesville, MD
21. Signature of Funeral Service Licensee Paige Haight Herbst		22. Name and Address of Facility Haight Funeral Home & Chapel P.O. Box 195 Sykesville, MD 21784		
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. a. Immediate Cause (Final disease or condition resulting in death) STROKE. RIGHT HEMISPHERIC Due to (or as a consequence of): MYOCARDIAL INFARCTION. APICAL b. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last ATRIAL FIBRILLATION Due to (or as a consequence of): c. d.				
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome pf pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. HYPERTENSION				
23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown				
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
		28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29b. Signature and title of certifier R. KANE M.D.		29c. License number DO 058580		29d. Date signed (Month, Day, Year) 04/13/2007
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BAI KANE 3233 SUPERIOR LN B21. BOWIE, MD 20715				
31. Date filed (Month, Day, Year) APR 17 2007		32. Registrar's Signature [Signature]		

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 12112

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Frances Marion Ford							2. Date of Death Month April Day 12 Year 2007	3. Time of Death 1:15 p M
	4a. Facility Name (If not institution, give street and number) 719 Maiden Choice Lane, BR-541			4b. City, Town, or Location of Death Catonsville			4c. County of Death Baltimore		
Funeral Director	5. Social Security Number 322-05-7120	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 96 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) FEB 20 1911	9. Birthplace (State or Foreign Country) Texas		
To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State MD 10b. County Baltimore 10c. City, Town or Location Catonsville							10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	10e. Street and Number 719 Maiden Choice Lane, BR-541			10f. Zip Code 21228			10g. Citizen of What Country? USA		
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College Counselor			16b. Kind of Business/Industry Higher Education		
	17. Father's Name (First, Middle, Last) Frank L. Ford				18. Mother's Name (First, Middle, Maiden Surname) Dorothy Lewis				
	19a. Informant's Name/Relationship (Type, Print) Florence F. Dart - sister				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 719 Maidenchoice Lane, BR-541, Catonsville, MD 21228				
Physician /Medical Examiner	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Metro Crematory, Inc. 4/13/2007		Date	20c. Location - City or Town, State Baltimore, MD		
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee Steven H. Williams			22. Name and Address of Facility Cremation Society of Maryland, Inc. 299 Frederick Road, Baltimore, MD 21228					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Congestive Heart Failure							Approximate Interval Between Onset and Death	
	23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown							23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Unknown	23d. Date of delivery Month Day Year
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide			28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred		
							28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) At home		
	29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.			29b. Signature and title of certifier Andy Lazaris MD					
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Andy Lazaris 719 Maiden choice Lane Catonsville Maryland			32. Registrar's Signature James A. Spahr			31. Date filed (Month, Day, Year) APR 17 2007		

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

Permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit

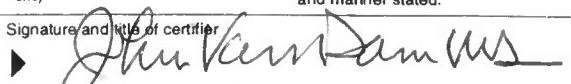
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2007 12113
Reg. No.

**1 - For
State
Registrar**

Physician /Medical Examiner Funeral Director To Be Completed by Funeral Director	1. Decedent's Name (First, Middle, Last) Edward Thomas Flaherty, Sr.				2. Date of Death Month Day Year April 14, 2007	3. Time of Death 7:20am						
	4a. Facility Name (If not institution, give street and number) 4004 Belnor Lane		4b. City, Town, or Location of Death Suitland		4c. County of Death Prince George's							
<p style="margin-left: 20px;">Baltimore, Maryland 21215-0036</p> <p>Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 26a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.</p>	5. Social Security Number 579-38-5109		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 77 Yrs.		If Under 1 Year Months Days Hours Min. If Yes, Give Year or Dates: 1950-1961		8. Date of Birth (Month, Day, Year) Dec. 3, 1929		9. Birthplace (State or Foreign Country) Washington, DC	
	10a. State Maryland		10b. County Prince George's		10c. City, Town or Location Suitland				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
	10e. Street and Number 4004 Belnor Lane				10f. Zip Code 20746		10g. Citizen of What Country? U.S.A.					
	11. Marital Status 1 <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White					
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Maintenance Worker		16b. Kind of Business/Industry General Maintenance							
	17. Father's Name (First, Middle, Last) Edward M. Flaherty				18. Mother's Name (First, Middle, Maiden Surname) Isabelle M. Wilson							
	19a. Informant's Name/Relationship (Type, Print) Barbara Flaherty (Wife)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4004 Belnor Lane Suitland, Maryland 20746							
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Resurrection Cemetery 2007		Date April 19, 2007		20c. Location - City or Town, State Clinton, Maryland					
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Lee Funeral Home, Inc. 6633 Old Alexandria Ferry Road Clinton, MD 20735							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)				Approximate Interval Between Onset and Death								
a. _____ Due to (or as a consequence of): Pancreatic Carcinoma												
b. _____ Due to (or as a consequence of):												
c. _____ Due to (or as a consequence of):												
d. _____												
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown						
						24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No						
						24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No						
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)										
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred				
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.												
29b. Signature and title of certifier 		29c. License number D30583		29d. Date signed (Month, Day, Year) April 16, 2007								
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) John Van Dan, M.D. 3508 Old Silver Hill Road, Suitland, MD 20746												
31. Date filed (Month, Day, Year) APR 17 2007		32. Registrar's Signature 										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2007 12 14

Reg. No.

1. For State
RegistrarPhysician/
Medical Examiner

1. Decedent's Name (First, Middle, Last)

Brent

Deon

Flanagan

2. Date of Death

Month

Day

Year

3. Time of Death

0515 hrs

Funeral
Director

4a. Facility Name (if not institution, give street and number)

2623 W. Coldspring Lane

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

5. Social Security Number

213-28-6505

6. Sex

 M F

7. Age (In yrs. last birthday)

16

If Under 1 Year

If Under 24 Hrs.

8. Date of Birth (MM/DD/YYYY)

05

03

90

9. Birthplace (State or
Foreign Country)

MD

10a. State

MD

10b. County

NA

10c. City, Town or Location

Baltimore

10d. Inside City Limits

 Yes No

10e. Street and Number

4433 Pall Mall Road

10f. Zip Code

21215

10g. Citizen of What Country?

U.S.A.

11. Marital Status

 Never Married Married Widowed Divorced12. Was Decedent Ever in U.S.
Armed Forces? Yes NoIf Yes, Give Year
or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No)
If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Yes No specify:14. Race - American Indian, Black,
White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

10th grade

College (1-4 or 5+)

na

16a. Decedent's Usual Occupation (Give kind of work done
during most of working life. DO NOT use retired)

Cashier

16b. Kind of Business/Industry

Wendy's

17. Father's Name (First, Middle, Last)

Earl Flanagan Jr.

18 Mother's Name (First, Middle, Maiden Surname)

Tracey Brooks

19a. Informant's Name/Relationship (Type, Print)

Tracey Brooks-Mother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4433 Pall Mall Road, Baltimore, Md 21215

20a. Method of Disposition

 Burial Cremation Removal from State Donation Other Specify:20b. Place of Disposition (Name of cemetery,
crematory or other place)

Mt. Zion

Date

4/18/07

20c. Location - City or Town, State

Baltimore, Md

21. Signature of Funeral Service Licensee

Dorothy C. Shipp

22. Name and Address of Facility

March F/H West

4300 Wabash Ave, Baltimore, Md 21215

Baltimore, MD 21215-0036

permit Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a show any
injury or other traumatic event, the Medical Examiner must be notified at once.Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease
or condition resulting in death)a. Multiple Sharp Force Injuries

Due to (or as a consequence of):

Approximate Interval
Between Onset and
DeathSequentially list conditions,
if any, leading to immediate
cause. Enter Underlying Cause
(Disease or injury that initiated
events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

 UNPENDED AMENDED

IF FEMALE:

23b. Was decedent pregnant in the
past 12 months?1 Yes 2 No 9 Unknown

23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 3 Ectopic pregnancy4 Pregnant at time of death 5 Other (Specify)9 Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy performed?

1 Yes 2 No

24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No25. Was case referred to medical
examiner?1 Yes 2 NoHospital: 1 Inpatient 2 ER/Outpatient 3 DOAOther: 4 Nursing Home 5 Residence 6 Other: Scene

27. Manner of Death

1 Natural 5 Pending
Investigation2 Accident 6 Could not be
determined3 Suicide 4 Homicide28a. Date of Injury
(Month, Day, Year)FOUND:
Apr 12, 2007

28b. Time of Injury

FOUND:
0515 hrs

28c. Injury at Work?

1 Yes 2 No

28d. Describe how injury occurred

Subject assaulted

28e. Place of Injury - At home, farm, street, factory, office building, etc.

(Specify) Multi-Family Apt.

28f. Location (Street and Number or Rural Route Number, City
or Town, State)

2623 W. Coldspring Lane, Baltimore, MD

29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

and manner stated.

29b. Signature and title of certifier

Tasha Greenberg MD. Assistant Medical Examiner

111 Penn Street, Baltimore, MD 21201

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

April 13, 2007

31. Date filed (Month, Day, Year)

APR 17 2007

32. Registrar's Signature

Leanne B. Hartle

ORIGINAL

Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar Amend 20b, per FH, G866, 4/25/07 Certificate of Death

Reg. No.

2007 12115

Physician/ Medical Examiner		1. Decedent's Name (First, Middle, Last) WILLIAM FERESEE						2. Date of Death Month Day Year April 12, 2007		3. Time of Death 0823 hrs					
Funeral Director		4a. Facility Name (if not institution, give street and number) Good Samaritan Hospital						4b. City, Town, or Location of Death Baltimore		4c. County of Death N/A					
To Be Completed by Funeral Director		5. Social Security Number 217 54 4983		6. Sex 1 M 2 F	7. Age (In yrs last birthday) 55 Yrs.	If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.	8. Date of Birth (MM/DD/YYYY) JAN. 30, 1952		9. Birthplace (State or Foreign Country) MD.				
Important: If item 27 is marked other than "natural", or items 25a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		10a. State MD.						10b. County N/A BALTIMORE		10c. City, Town or Location BALTO. ESSEX		10d. Inside City Limits 1 X Yes 2 No			
Baltimore, MD 21215-0036		10e. Street and Number 1420 GITTINGS AVE.						10f. Zip Code 21239		10g. Citizen of What Country? USA					
To Be Completed by Physician/Medical Examiner		11. Marital Status 1 Never Married 2 Married		12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No specify:		14. Race - American Indian, Black, White, etc. Specify: BLACK							
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial transit		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12TH						16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) SANITATION		16b. Kind of Business/Industry BALTIMORE CITY SANITATION DEPT.					
Important: If item 27 is marked other than "natural", or items 25a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		17. Father's Name (First, Middle, Last) WILLIAM COLICK						18. Mother's Name (First, Middle, Maiden Surname) BERTHA FERESEE							
To Be Completed by Physician/Medical Examiner		19a. Informant's Name/Relationship (Type, Print) BERTHA FERESEE (mother)						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1420 GITTINGS AVE. ESSEX, MD. 21239							
Important: If item 27 is marked other than "natural", or items 25a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State		20b. Place of Disposition (Name of cemetery, crematory or other place) Trinity Cem		Date April 24, 2007		20c. Location - City or Town, State APR. 19, 2007 BALTO., MD.							
Important: If item 27 is marked other than "natural", or items 25a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Licensee Bernadine J. Geey						22. Name and Address of Facility CALVIN B. SCRUGGS FUNERAL HOME 1412 E. PRESTON ST. BALTO. MD. 21213							
Important: If item 27 is marked other than "natural", or items 25a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)						Approximate Interval Between Onset and Death							
Important: If item 27 is marked other than "natural", or items 25a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		a. Atherosclerotic cardiovascular disease Due to (or as a consequence of):													
Important: If item 27 is marked other than "natural", or items 25a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		b. _____ Due to (or as a consequence of):													
Important: If item 27 is marked other than "natural", or items 25a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		c. _____ Due to (or as a consequence of):													
Important: If item 27 is marked other than "natural", or items 25a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		d. _____													
Important: If item 27 is marked other than "natural", or items 25a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		<input checked="" type="checkbox"/> UNPENDED		<input checked="" type="checkbox"/> AMENDED ITEM#10b, c, per FH, G866, 4/17/07, WS // #23a, 27, per ME, G866, 4/19/07 TT											
Important: If item 27 is marked other than "natural", or items 25a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown		23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (Specify) 9 Unknown						23d. Date of delivery Month Day Year					
Important: If item 27 is marked other than "natural", or items 25a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown							
Important: If item 27 is marked other than "natural", or items 25a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.								24a. Was an autopsy performed? 1 Yes 2 No					24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No		
Important: If item 27 is marked other than "natural", or items 25a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		25. Was case referred to medical examiner? 1 Yes 2 No		26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other											
Important: If item 27 is marked other than "natural", or items 25a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		27. Manner of Death 1 X Natural 5 Pending Investigation 2 Accident 6 Could not be determined 3 Suicide 4 Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury		28c. Injury at Work?		28d. Describe how injury occurred					
Important: If item 27 is marked other than "natural", or items 25a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.								1 Yes 2 No							
Important: If item 27 is marked other than "natural", or items 25a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)								28f. Location (Street and Number or Rural Route Number, City or Town, State)					
Important: If item 27 is marked other than "natural", or items 25a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.													
Important: If item 27 is marked other than "natural", or items 25a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		29b. Signature and title of certifier Tasha Greenberg MD. Assistant Medical Examiner		29c. License number O.C.M.E.						29d. Date signed (Month, Day, Year) April 13, 2007					
Important: If item 27 is marked other than "natural", or items 25a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		30. Name and address of person who completed cause of death (Item 23a) Tasha Greenberg MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201													
Important: If item 27 is marked other than "natural", or items 25a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		31. Date filed (Month, Day, Year) APRIL 17 2007		32. Registrar's Signature [Signature]											
State Registrar		ORIGINAL													

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 12116

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Marguerite R. Fahey				2. Date of Death Month April Day 11 Year 2007	3. Time of Death 5:15 aM		
	4a. Facility Name (If not institution, give street and number) Gilchrist		4b. City, Town, or Location of Death Towson		4c. County of Death Baltimore			
Funeral Director	5. Social Security Number 212-74-0487	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 88 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Hours	8. Date of Birth (Month, Day, Year) June 9, 1918	9. Birthplace (State or Foreign Country) Pennsylvania	
To Be Completed by Funeral Director	10a. State Md. 10b. County Baltimore				10c. City, Town or Location Cockeysville			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	10e. Street and Number 10138 Charington Rd.			10f. Zip Code 21030			10g. Citizen of What Country? USA	
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Homemaker		16b. Kind of Business/Industry Own Home			
	17. Father's Name (First, Middle, Last) James Sweeney				18. Mother's Name (First, Middle, Maiden Surname) Catherine Evans			
	19a. Informant's Name/Relationship (Type, Print) Mr. Thomas Fahey/ Husband		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10138 Charington Rd. Cockeysville, Md. 21030		Date 4-14-07	20c. Location - City or Town, State Timonium, Md.		
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Dulaney Valley Mem.					
	21. Signature of Funeral Service Licensee ► <i>[Signature]</i>		22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204					
Physician /Medical Examiner	23a. Part I. Enter the disease(s) or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of): Dementia b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):						Approximate Interval Between Onset and Death years	
	23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____ <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year			
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Medical Certification: To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) Hospice						
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide	28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred		
	28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)					28f. Location (Street and Number or Rural Route Number, City or Town, State)		
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
	29b. Signature and title of certifier ► <i>[Signature]</i>		29c. License number D 58303		29d. Date signed (Month, Day, Year) April 11 2007			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JASON J CHARLES, MD 6701 N Charles St Towson, MD 21204							
State Registrar	31. Date filed (Month, Day, Year) APR 17 2007	32. Registrar's Signature ► <i>[Signature]</i>						

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2007 12117

1 - For
State
Registrar

Physician
/Medical
Examiner

Funeral
Director

To Be Completed by Funeral Director

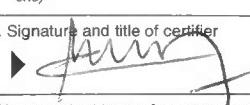
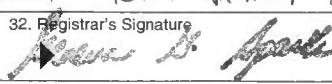
Joseph Fabula

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit once.

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month 04 Day 10 Year 2007		3. Time of Death 18:52 M
Joseph M. Fabula, Sr.		4b. City, Town, or Location of Death BALTIMORE		4c. County of Death N/A
4a. Facility Name (If not institution, give street and number) Good Samaritan Hospital		4b. City, Town, or Location of Death BALTIMORE		4c. County of Death N/A
5. Social Security Number 219 034 697		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) 86 Yrs.	8. Date of Birth (Month, Day, Year) July 30, 1920
9. Birthplace (State or Foreign Country) Maryland		10. If Under 1 Year Months Days Hours Min.		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
Usual Residence of Decedent Maryland Baltimore		10c. City, Town or Location Essex		
10e. Street and Number 329 Miles Road		10f. Zip Code 21221		10g. Citizen of What Country? U.S.A.
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year of Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: 14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) 1		16b. Kind of Business/Industry Teamsters President Trucking
17. Father's Name (First, Middle, Last) Joseph W. Fabula		18. Mother's Name (First, Middle, Maiden Surname) Anna K. Koch		
19a. Informant's Name/Relationship (Type, Print) Mark Fabula/Son		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 329 Miles Road Baltimore MD 21221		
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Holy Rosary Cem.		20c. Date 04/14/2007
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Miller-Dippel Funeral Home, Inc. 6415 Belair Road Baltimore MD 21206		20c. Location - City or Town, State Baltimore MD
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		Approximate Interval Between Onset and Death		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				
<p>a. Acute Myocardial Infarction Due to (or as a consequence of): Coronary Artery Disease</p> <p>b. Due to (or as a consequence of): Arteriosclerotic Cardiovascular Disease</p> <p>c. Due to (or as a consequence of):</p> <p>d.</p>				
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Mesenteric ischemia Atrial fibrillation.		23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 28d. Describe how injury occurred
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		
29b. Signature and title of certifier  md		29c. License number RES 000		29d. Date signed (Month, Day, Year) 04, 10, 2007
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Karima Benamour, 5601 Loch Raven Blvd., Baltimore, MD 21239.				
31. Date filed (Month, Day, Year) APR 17 2007		32. Registrar's Signature 		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 12118

1- For State
Registrar

Physician/ Medical Examiner	1. Decedent's Name (First, Middle, Last) Walker Gladden, Jr.					2. Date of Death Month Day Year April 11, 2007	3. Time of Death 0721 hrs
	4a. Facility Name (if not institution, give street and number) 6942 Milbrook Park Drive Apt. T3 6942 Milbrook Park Drive Apt. T3		4b. City, Town, or Location of Death Pikesville		4c. County of Death Baltimore County		
Funeral Director	5. Social Security Number 213-36-2036	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 66 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (MM/DD/YYYY) Dec. 3 1940	9. Birthplace (State or Foreign Country) MD
	10a. State MD		10b. County Baltimore		10c. City, Town or Location Pikesville		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
10e. Street and Number 6942 Milbrook Park Drive Apt. T3			10f. Zip Code 21215		10g. Citizen of What Country? USA		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No specify:		14. Race - American Indian, Black, White, etc. Specify: Black	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 9th Grade		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Laborer		16b. Kind of Business/Industry Private Industry			
17. Father's Name (First, Middle, Last) Walker Gladden, Sr.				18. Mother's Name (First, Middle, Maiden Surname) Rosie Eldridge			
19a. Informant's Name/Relationship (Type, Print) Jacqueline Gladden / Daughter		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Apt. T3 21215 Milbrook Park Dr. Pikesville, Md					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other Specify: Mt. Zion Cemetery		20b. Place of Disposition (Name of cemetery, crematory or other place) Mt. Zion Cemetery		Date 4/16/07	20c. Location - City or Town, State Lansdowne, MD		
21. Signature of Funeral Service Licensee <i>[Signature]</i>				22. Name and Address of Facility Chatman-Harris Funeral Home 5240 Reisterstown Rd. Baltimore, MD			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Lung cancer Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. _____ Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____							
<input type="checkbox"/> UNPENDED		<input checked="" type="checkbox"/> AMENDED ITEM#4a, perPHYS., G866, 4/17/07, WS					
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) g <input type="checkbox"/> Unknown				23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown							
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other: Scene					
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	
						28d. Describe how injury occurred	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)							
28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
29b. Signature and title of certifier <i>[Signature]</i>				29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) April 11, 2007	
30. Name and address of person who completed cause of death (Item 23a) Ling Li, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201							
31. Date filed (Month, Day, Year) APR 17 2007		32. Registrar's Signature <i>[Signature]</i>					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 12119

1 - For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Judith A. Gildee					2. Date of Death Month Day Year April 7, 2007	3. Time of Death 12:55 PM	
	4a. Facility Name (If not institution, give street and number) Stella Maris Hospice			4b. City, Town, or Location of Death Timonium		4c. County of Death Baltimore		
Funeral Director	5. Social Security Number 216-48-0174	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 59 Yrs.	If Under 1 Year Months Days Hours Min.	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) June 18, 1947	9. Birthplace (State or Foreign Country) Maryland	
	Usual Residence of Decedent 10a. State MD 10b. County Baltimore			10c. City, Town or Location Towson			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
To Be Completed by Funeral Director	10e. Street and Number 835 Bosley Avenue			10f. Zip Code 21204		10g. Citizen of What Country? USA		
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: white		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) unk		16b. Kind of Business/Industry unk			
	17. Father's Name (First, Middle, Last) Roland L. Brown			18. Mother's Name (First, Middle, Maiden Surname) Dorothy H. Hubbard				
	19a. Informant's Name/Relationship (Type. Print) Wilson Gildee/former spouse			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2212 Tufton Ridge Road Reisterstown, MD 21136				
Physician /Medical Examiner	20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place)		Date	20c. Location - City or Town, State		
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201					
	23a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)						Approximate Interval Between Onset and Death	
	<p>a. LUNG CANCER Due to (or as a consequence of):</p> <p>b. Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. Due to (or as a consequence of):</p>							
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome pf pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown <input type="checkbox"/> Other (specify) _____		23d. Date of delivery Month Day Year			
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
							24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) HOSPICE					
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred		
			28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
	29b. Signature and title of certifier 		29c. License number D43725		29d. Date signed (Month, Day, Year) 4/19/07			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. TARIQ MAHMOOD 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093							
State Registrar	31. Date filed (Month, Day, Year) APR 17 2007		32. Registrar's Signature 					

APRIL 7, 2007 12:55 p.m.

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

JUDITH GILDEE

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 12120

1- For State Registrar

Physician /Medical Examiner		1. Decedent's Name (First, Middle, Last) Francesca Greco					2. Date of Death Month Day Year April 12, 2007		3. Time of Death 12:05p M	
Funeral Director		4a. Facility Name (If not institution, give street and number) Gilchrist Hospice Center			4b. City, Town, or Location of Death Towson			4c. County of Death Baltimore		
To Be Completed by Funeral Director		5. Social Security Number 216-36-8919	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 99 Yrs.	If Under 1 Year Months 0	If Under 24 Hrs. Hours 0	Min. 0	8. Date of Birth (Month, Day, Year) JUN 6, 1907	9. Birthplace (State or Foreign Country) Italy	
		Usual Residence of Decedent 10a. State Maryland			10b. County Howard			10c. City, Town or Location Sykesville		
		10e. Street and Number 14236 Forsythe Road			10f. Zip Code 21784			10g. Citizen of What Country? Italy		
		11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: 5		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: White		14. Race - American Indian, Black, White, etc. Specify: White		
		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 5		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Seamstress		16b. Kind of Business/Industry Suit Manufacturer				
		17. Father's Name (First, Middle, Last) Nicolo Incaprera				18. Mother's Name (First, Middle, Maiden Surname) Teresa Culotta				
Physician /Medical Examiner		19a. Informant's Name/Relationship (Type, Print) Anna Fiduccia			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14236 Forsythe Rd. Sykesville, MD 21784					
		20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) Druid Ridge Cemetery			20b. Place of Disposition (Name of cemetery, crematory or other place) Druid Ridge Cemetery			Date 4/16/2007	20c. Location - City or Town, State Baltimore, MD	
		21. Signature of Funeral Service Licensee Dawn McDonald			22. Name and Address of Facility Haight Funeral Home & Chapel, P.A. P.O. Box 195 Sykesville, MD 21784 (410-795-1400)					
		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)			23b. Part II. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last			23c. Approximate Interval Between Onset and Death days		
		a. Due to (or as a consequence of): aspiration pneumonia			b. Due to (or as a consequence of): dysphagia			c. Due to (or as a consequence of): Dementia		
		d.								
		23d. IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown			23c. If yes, outcome pf pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year		
		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
								24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		
		25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) Hospice					
		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide			28a. Date of Injury (Month, Day Year) M 28b. Time of Injury M 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			28d. Describe how injury occurred		
					28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) At home			28f. Location (Street and Number or Rural Route Number, City or Town, State)		
		29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
		29b. Signature and title of certifier M. Anthony Riley, MD			29c. License number D25205			29d. Date signed (Month, Day, Year) April 12, 2007		
		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) W.A. Riley Gmc 6701 N. Charles St. Balto. Md 21207								
State Registrar		31. Date filed (Month, Day, Year) APR 17 2007		32. Registrar's Signature Paul B. Spoto						

Division or Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

Greco, Francesca, MD
Division or Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

5
State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 1212

1- For State Registrar**Physician/
Medical Examiner**

1. Decedent's Name (First, Middle, Last)	MARY C. GORSUCH				2. Date of Death Month Day Year April 15, 2007	3. Time of Death 1046 hrs
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Funeral Director

4a. Facility Name (if not institution, give street and number) Franklin Square Hospital	4b. City, Town, or Location of Death Rosedale				4c. County of Death Baltimore County	
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To Be Completed by Funeral Director

5. Social Security Number 061-50-9727	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 39 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Hours	8. Date of Birth (MM/DD/YYYY) 1-1-1968	9. Birthplace (State or Foreign Country) N.Y.
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Usual Residence of Decedent
10a. State MD 10b. County BALTIMORE 10c. City, Town or Location ROSEDALE 10d. Inside City Limits
 Yes No

10e. Street and Number 1807 GREENCASTLE DRIVE	10f. Zip Code 21237	10g. Citizen of What Country? U.S.A.
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11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No specify: Specify: WHITE	14. Race - American Indian, Black, White, etc.
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15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 6	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) HOMEMAKER	16b. Kind of Business/Industry OWN HOME
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17. Father's Name (First, Middle, Last) JOSEPH BRAUN	18. Mother's Name (First, Middle, Maiden Surname) DOROTHY (RATHBURN)
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19a. Informant's Name/Relationship (Type, Print) JOHN PAUL GORSUCH / HUSBAND	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1807 GREENCASTLE DRIVE ROSEDALE, MD 21237
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20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other Specify	20b. Place of Disposition (Name of cemetery, crematory or other place) METRO CREMATORY	Date 4-17-07	20c. Location - City or Town, State CATONSVILLE, MD
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21. Signature of Funeral Service Licensee 	22. Name and Address of Facility CVACH / ROSEDALE FUNERAL HOME 1211 CHESACO AVE ROSEDALE, MD 21237
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Baltimore, MD 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23 or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)	a Complications of cocaine intoxication and opiate use Due to (or as a consequence of):	Approximate Interval Between Onset and Death
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Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):	c. Due to (or as a consequence of):	d. Due to (or as a consequence of):
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<input checked="" type="checkbox"/> UNPENDED	<input type="checkbox"/> AMENDED #23a,27,28a-f, perME, g866, 4/26/07 TT	23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown	23d. Date of delivery Month Day Year
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23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input checked="" type="checkbox"/> Unknown	23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown	23d. Date of delivery Month Day Year
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Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown
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23f. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No
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25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other:
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27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide	28a. Date of Injury (Month, Day, Year) Fnd 4/14/2007	28b. Time of Injury Fnd 3:00 pm	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	28d. Describe how injury occurred unk
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28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State) unk
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29a. Certifier 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier 	29c. License number O.C.M.E.	29d. Date signed (Month, Day, Year) April 16, 2007
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30. Name and address of person who completed cause of death (Item 23a) Carol Allan, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

31. Date filed (Month, Day, Year) APR 17 2007	32. Registrar's Signature
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State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 12122

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Lorraine Hall							2. Date of Death Month April Day 12th Year 2007	3. Time of Death 9:30 AM
	4a. Facility Name (If not institution, give street and number) Howard County General Hospital			4b. City, Town, or Location of Death Columbia		4c. County of Death Howard			
Funeral Director	5. Social Security Number 319-34-5503	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 69 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Hours	8. Date of Birth (Month, Day, Year) 05-21-1937	9. Birthplace (State or Foreign Country) MD		
To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State MD 10b. County Howard 10c. City, Town or Location Jessup							10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	10e. Street and Number 8760 Mary Lane			10f. Zip Code 20794			10g. Citizen of What Country? USA		
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: Black	
	15. Decedent's Education (Specify only highest grade completed) 10th			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Maintenance			16b. Kind of Business/Industry Montgomery General		
	17. Father's Name (First, Middle, Last) John Calvin Luby			18. Mother's Name (First, Middle, Maiden Surname) Mary Frances Harris					
	19a. Informant's Name/Relationship (Type, Print) Geneva Jayne Colbert (Friend)			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8760 Mary Lane, Jessup, MD 20794					
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory, or other place) Maryland National 4-20-07			Date Laurel, MD	20c. Location - City or Town, State	
	21. Signature of Funeral Service Licensee Raughn C. Greene			22. Name and Address of Facility Raughn C. Greene Funeral Services					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)			23b. Approximate Interval Between Onset and Death Metabolic Acidosis					
	<p>a. Due to (or as a consequence of): Myocardial infarction</p> <p>b. Due to (or as a consequence of): leptic shock</p> <p>c. Due to (or as a consequence of): Hypertension</p>								
Physician /Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown			23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year		
Medical Certification: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Diabetic ketoacidosis respiratory failure			23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown					
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide			28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred		
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)		
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.			29c. License number D50870			29d. Date signed (Month, Day, Year) April 12th 2007		
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Suzan A. Kelly 5005 Signal Bell Lane Clarksville MD								
State Registrar	31. Date filed (Month, Day, Year) APR 17 2007			32. Registrar's Signature Suzan A. Kelly					

Baltimore, Maryland 21215-0036

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 12123

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Barbara Lee Hansen							2. Date of Death Month April	Day 5	Year 2007	3. Time of Death 9:24 P M	
	4a. Facility Name (If not institution, give street and number) Union Memorial Hospital							4b. City, Town, or Location of Death Baltimore			4c. County of Death N/A	
Funeral Director	5. Social Security Number 218-36-3326	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 67 Yrs.	If Under 1 Year Months 0	If Under 24 Hrs. Days 0	Hours 0	Min. 0	8. Date of Birth (Month, Day, Year) Jan. 24, 1940	9. Birthplace (State or Foreign Country) Maryland			
	Usual Residence of Decedent 10a. State Maryland							10b. County N/A			10c. City, Town or Location Baltimore	
10e. Street and Number 1328 Morling Avenue							10f. Zip Code 21211			10g. Citizen of What Country? USA		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: 12			13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: White				14. Race - American Indian, Black, White, etc. Specify: White			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Secretary				16b. Kind of Business/Industry Window Supply				
17. Father's Name (First, Middle, Last) William Alger							18. Mother's Name (First, Middle, Maiden Surname) Margaret Hubbs					
19a. Informant's Name/Relationship (Type, Print) Anita Hansen Daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2709 A Fallston Road, Fallston, MD 21047								
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) ► Lynn B. Hansen				20b. Place of Disposition (Name of cemetery, crematory or other place) St. Abraham's Cemetery			Date 4/11/2007	20c. Location - City or Town, State Beckleysville, MD				
21. Signature of Funeral Service Licensee Lynn B. Hansen				22. Name and Address of Facility Burgee-Henss-Seitz Funeral Home, Inc. 21211 3631 Falls Road, Baltimore, Maryland								
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							Approximate Interval Between Onset and Death <1 minute					
<p>a. Due to (or as a consequence of): cardiopulmonary Arrest</p> <p>b. Due to (or as a consequence of): Endocarditis</p> <p>c. Due to (or as a consequence of): End Stage Renal Disease</p> <p>d. Due to (or as a consequence of):</p>							2 years					
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown				23c. If yes, outcome pf pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown 5. Other (specify)					23d. Date of delivery Month Day Year			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown					
							24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
							24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA					Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred						
		28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.												
29b. Signature and title of certifier Igor Belyansky		29c. License number 222943					29d. Date signed (Month, Day, Year) April 5, 2007					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) IGOR BELYANSKY M.D.												
31. Date filed (Month, Day, Year) APR 17 2007		32. Registrar's Signature Lynn B. Hansen										

Baltimore, Maryland 21215-0036
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 12124

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Louise D. Haneke					2. Date of Death Month April Day 10 Year 2007	3. Time of Death 4:20 PM	
	4a. Facility Name (If not institution, give street and number) BALTIMORE WASHINGTON MEDICAL CENTER			4b. City, Town, or Location of Death Glen Burnie		4c. County of Death Anne Arundel		
Funeral Director	5. Social Security Number 225-10-0859	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 96 Yrs.	If Under 1 Year Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	8. Date of Birth (Month, Day, Year) July 24, 1910		9. Birthplace (State or Foreign Country) Maryland	
To Be Completed by Funeral Director	10a. State MD 10b. County Anne Arundel 10c. City, Town or Location Severna Park					10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
	10e. Street and Number 600 McKinsey Park Drive #302			10f. Zip Code 21146		10g. Citizen of What Country? USA		
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: white		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 0	bookkeeper		16b. Kind of Business/Industry furniture		
	17. Father's Name (First, Middle, Last) Henry Louis Haneke Sr				18. Mother's Name (First, Middle, Maiden Surname) Catherine Rochlitz			
	19a. Informant's Name/Relationship (Type, Print) Anna Haneke/sister			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 600 McKinsey Park Drive #403 Severna Park, MD 21146				
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place)		Date	20c. Location - City or Town, State		
Physician /Medical Examiner	21. Signature of Funeral Service Licensee Ronald S. Wade, Director		22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause Final disease or condition resulting in death Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							
	<p>a. <i>Acute respiratory failure</i> Due to (or as a consequence of): Days</p> <p>b. <i>Septic shock</i> Due to (or as a consequence of): Days</p> <p>c. <i>Cardiac Arrest (Myocardial infarction)</i> Due to (or as a consequence of): Days</p> <p>d. <i>Anoxic Encephalopathy</i> Due to (or as a consequence of): Days</p>							
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____ <input type="checkbox"/> Unknown				23d. Date of delivery Month Day Year	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Asphyxiation						23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA		Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) _____		26. Place of Death (Check only one)	
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year) <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred	
			28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
	29b. Signature and title of certifier Louise D. Haneke		29c. License number J-46761		29d. Date signed (Month, Day, Year) APR 17 2007			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Louise D. Haneke, Glen Burnie, MD 21061							
State Registrar	31. Date filed (Month, Day, Year) APR 17 2007		32. Registrar's Signature Louise D. Haneke					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 12125

1 - For
State
Registrar

Physician
/Medical
Examiner

Baltimore, Maryland 21215-0036
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.

To Be Completed by Funeral Director

1. Decedent's Name (First, Middle, Last)		2. Date of Death				3. Time of Death	
BERRY RICHARDS HUBBARD		Month Day Year April 14, 2007				8:25 P M	
4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of Death				4c. County of Death	
Greater Baltimore Medical Center		Towson				Baltimore	
5. Social Security Number		6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	9. State or Foreign Country
095-14-1765		<input type="checkbox"/> M <input checked="" type="checkbox"/> F	89	Yrs.	Months Days Hours Min.	(Month, Day, Year) 10/27/1917	MINNESOTA
Usual Residence of Decedent							
10a. State	10b. County	10c. City, Town or Location					
MD	BALTIMORE	LUTHERVILLE					
10e. Street and Number			10f. Zip Code			10g. Citizen of What Country?	
513 BRIGHTWOOD CLUB DR.			21093			USA	
11. Marital Status		12. Was Decedent Ever in U.S. Armed Forces?		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)			14. Race - American Indian, Black, White, etc.
<input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			Specify: WHITE
15. Decedent's Education (Specify only highest grade completed)			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)			16b. Kind of Business/Industry	
Elementary/Secondary (0-12)		College (1-4 or 5+)		HOUSEWIFE			HOMEMAKER
17. Father's Name (First, Middle, Last)				18. Mother's Name (First, Middle, Maiden Surname)			
ERNEST THOMSON FRAZIER RICHARDS				VIRGINIA B. SCHUNMAN			
19a. Informant's Name/Relationship (Type, Print)			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)				
T.B. HUBBARD (SON)			915 OLD ORCHARD RD. CHAPEL HILL, N.C. 27517				
20a. Method of Disposition		20b. Place of Disposition (Name of cemetery, crematory or other place)			Date	20c. Location - City or Town, State	
<input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		ST. THOMAS GARRISON			04/20/07	OWINGS MILLS, MD.	
21. Signature of Funeral Service Licensee		22. Name and Address of Facility					
<i>Walter L. Hubbard</i>		HENRY W. JENKINS & SONS CO. 16924 YORK RD MONKTON, MD. 21111.					

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)		2 days
a. Hypoxia		
Due to (or as a consequence of):		
b. Uremia		
Due to (or as a consequence of):		
c. Dehydration		
Due to (or as a consequence of):		
d.		

IF FEMALE:	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown <input type="checkbox"/> Other (Specify) _____	23d. Date of delivery Month Day Year
	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown

25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA	Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)	26. Place of Death Check one
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27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred
	28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)	1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
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29b. Signature and title of certifier <i>Allison Habas</i>	29c. License number D63312	29d. Date signed (Month, Day, Year) April 16, 2007
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31. Date filed (Month, Day, Year) APR 17 2007	32. Registrar's Signature <i>Leanne B. Hall</i>
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Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28e below any injury or other traumatic event, the Medical Examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
amend item 1 per doc., 20a-c, 22 per fh, 8866 4-30-07 v 2007 12126

State of Maryland / Department of Health and Mental Hygiene

1- For State Amend #17, 18, per FH, 8867, 5/2/07 TT Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Olukunle David Ishola				2. Date of Death Month April Day 9 Year 2007		3. Time of Death 548 PM
	4a. Facility Name (If not institution, give street and number) Northwest Hospital Center		4b. City, Town, or Location of Death Randallstown, Maryland		4c. County of Death Baltimore		
Funeral Director	5. Social Security Number 216-75-3232	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 61 Yrs.	If Under 1 Year Months 0	If Under 24 Hrs. Days 0	Hours 0	Min. 0
					8. Date of Birth (Month, Day, Year) June 19, 1945	9. Birthplace (State or Foreign Country) Nigeria	
Usual Residence of Decedent							
10a. State MD		10b. County Baltimore		10c. City, Town or Location Randallstown		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number 9330 Tulsemere Road				10f. Zip Code 21133		10g. Citizen of What Country? Nigeria	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: 1990		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: black		14. Race - American Indian, Black, White, etc. Specify: black	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 9		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Cleaning person		16b. Kind of Business/Industry fast food			
17. Father's Name (First, Middle, Last) John Ishola				18. Mother's Name (First, Middle, Maiden Surname) Adeoti (unknown)			
19a. Informant's Name/Relationship (Type, Print) Olusoji Ishola/son				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9330 Tulsemere Road Randallstown, MD 21133			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input checked="" type="checkbox"/> Other (Specify) in state		20b. Place of Disposition (Name of cemetery, crematory or other place) Ishola Family Plot		Date 5-13-07	20c. Location - City or Town, State Ibadan, Nigeria		
21. Signature of Funeral Service Licensee Ronald S. Wade, Director							
22a. Part I. Enter the disease, e., complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) atherosclerotic cardiovascular disease							
Approximate Interval Between Onset and Death							
22b. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							
22c. Due to (or as a consequence of): a.							
22d. Due to (or as a consequence of): b.							
22e. Due to (or as a consequence of): c.							
22f. Due to (or as a consequence of): d.							
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) Unknown		23d. Date of delivery Month Day Year			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown							
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No							
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input checked="" type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)							
28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
29b. Signature and title of certifier Erica Tobin Muddane, MD		29c. License number D0092760		29d. Date signed (Month, Day, Year) April 9, 2007			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Erica Tobin Muddane, MD 5401 Old Court Road Randallstown, Maryland 21133							
31. Date filed (Month, Day, Year) APR 17 2007		32. Registrar's Signature Erica A. Parker					

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

END TIME 7, 8, 17, 20b, per H C866, 4/17/07, WS

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2007 12127

1- For
State
RegistrarPhysician
/Medical
ExaminerFuneral
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
 Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

1. Decedent's Name (First, Middle, Last)

NATHANIEL JACKSON

4a. Facility Name (If not institution, give street and number)

UNIVERSITY OF MARYLAND

Certificate of Death

Reg. No.

2. Date of Death

4 / 10 / 07

3. Time of Death
830 AM

5. Social Security Number

229 28 2745

6. Sex

M

7. Age (In yrs. last birthday)

82 81 Yrs.

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

N/A

8. Date of Birth (Month, Day, Year)

1926

3 / 22 / 25

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State

MD

10b. County

N/A

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

 Yes No

10e. Street and Number

401 E. 25th Street

#C-4

10f. Zip Code

21218

10g. Citizen of What Country?

USA

11. Marital Status

1 Never Married 2 Married
3 Widowed 4 Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 Yes 2 No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
7th grade

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Laborer

16b. Kind of Business/Industry

Private Industry

17. Father's Name (First, Middle, Last)
Willie Jackson
Butter Bean willie Jackson18. Mother's Name (First, Middle, Maiden Surname)
Ella Jackson

19a. Informant's Name/Relationship (Type, Print)

Josephine Baskerville/Sister 2 Cypress Lane Belvedere, N.J. 07823

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Mr. Camel Trinity Cemetery

Date

20c. Location - City or Town, State

4 / 14 / 07

Dundalk, Maryland

21. Signature of Funeral Service Licensed

► Jerry Harr

22. Name and Address of Facility Chatman-Harris Funeral Home

5240 Reisterstown Road Baltimore, Md 21215

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Approximate Interval Between Onset and Death

a. CLOSTRIDIUM DIFFICILE COLITIS

Due to (or as a consequence of):

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No
9 Unknown23c. If yes, outcome pf pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown23d. Date of delivery
Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 Yes 2 No 3 Probably 4 Unknown

25. Was case referred to medical examiner?

1 Yes 2 No

26. Place of Death (Check only one)

Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)

27. Manner of Death

1 Natural 5 Pending investigation
2 Accident 6 Could not be determined
3 Suicide 4 Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

M 1 Yes 2 No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

► Kimberly Gworne MD

29c. License number

AV4176435 G17416

29d. Date signed (Month, Day, Year)

4 / 10 / 07

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Kimberly Gworne

225 Greene St, Baltimore, MD 21201

31. Date filed (Month, Day, Year)

APR 17 2007

32. Registrar's Signature

Kerry L. Gworne

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 12123

1- For
State
Registrar

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Lemuel E Jackson

2. Date of Death

Month Day Year
April 14 2007

3. Time of Death

1:30 A M

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Baltimore Washington Medical Center

4b. City, Town, or Location of Death

Glen Burnie

4c. County of Death

Anne Arundel

To Be Completed by Funeral Director

5. Social Security Number

216-24-0970

6. Sex

M

F

7. Age (In yrs. last birthday)

86 Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Days

8. Date of Birth

(Month, Day, Year)

4-17-1920

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

ANNNE ARUNDEL

10c. City, Town or Location

MILLERSVILLE

10d. Inside City Limits

Yes No

10e. Street and Number

441 Obrecht Road

10f. Zip Code

21108

10g. Citizen of What Country?

USA

11. Marital Status

Never Married Married
 Widowed Divorced

12. Was Decedent Ever in U.S. Armed Forces?

Yes No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

Yes No
Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12) 3

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Mechanic

16b. Kind of Business/Industry

Automotive

17. Father's Name (First, Middle, Last)

Lemuel John Jackson

18. Mother's Name (First, Middle, Maiden Surname)

Mabel Rebecca Grover

19a. Informant's Name/Relationship (Type, Print)

Mr. James L. Jackson/son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

210 Main Ave SW Glen Burnie MD 21061

20a. Method of Disposition

Burial Cremation Removal from State
 Donation Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Glen Haven Cemetery

Date

4/18/2007

20c. Location - City or Town, State

Glen Burnie, MD

21. Signature of Funeral Service Licensee

► [Signature] M01364

22. Name and Address of Facility

Singleton Funeral Home
1 Second Ave SW Glen Burnie MD 21061

Approximate Interval Between Onset and Death

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. GASTROINTESTINAL BLEEDING.

Due to (or as a consequence of):

b. END STAGE HEART DISEASE

Due to (or as a consequence of):

c. ANEMIA

Due to (or as a consequence of):

d. CHRONIC OBSTRUCTIVE PULMONARY DISEASE

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

Yes No

9 Unknown

23c. If yes, outcome pf pregnancy

Live birth Fetal death Ectopic pregnancy
 Pregnant at time of death Other (Specify)

9 Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

Yes No Probably Unknown

25. Was case referred to medical examiner?

Yes No

Hospital: 1 Inpatient

2 ER/Outpatient

3 DOA

Other: 4 Nursing Home

5 Residence

6 Other (Specify)

26. Place of Death (Check only one)

27. Manner of Death

1 Natural

5 Pending investigation

2 Accident

3 Suicide

4 Homicide

6 Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 Yes

2 No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

► [Signature]

MD

29c. License number

D 45149

29d. Date signed (Month, Day, Year)

APR 14 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

► [Signature] 301 Hospital Drive Glen Burnie MD 21061

31. Date filed (Month, Day, Year)

APR 17 2007

32. Registrar's Signature

[Signature]

Division or Vital Records

P.O. Box 68760, MD

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

5

Within 24 hours after death.

To the Physician/Medical Examiner: After this certificate has been signed by the attending physician and completely filled in by the physician or medical examiner, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

REPLACEMENT

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar Amend Item 21 per dvr, g868, 06/22/07 DIB Certificate of Death

Reg. No. 2007-12129

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>Clementine Kennedy</i>						2. Date of Death Month Day Year <i>April 15 2007</i>	3. Time of Death <i>1:15 PM</i>	
	4a. Facility Name (If not institution, give street and number) <i>1 Glenora Place</i>			4b. City, Town, or Location of Death <i>Bel Air</i>			4c. County of Death <i>Harford</i>		
Funeral Director	5. Social Security Number <i>215-34-9936</i>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <i>95</i> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <i>July 30, 1911</i>	9. Birthplace (State or Foreign Country) <i>Germany</i>	
	Usual Residence of Decedent 10a. State MD 10b. County Harford 10c. City, Town or Location Bel Air 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
To Be Completed by Funeral Director	10e. Street and Number 1 Glenora Place				10f. Zip Code 21014		10g. Citizen of What Country? USA		
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: <i>1945</i>		13. Was Decedent of Hispanic Origin? (Specify Yes or No) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: <i>No</i>		14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker		16b. Kind of Business/Industry Own Home			
	17. Father's Name (First, Middle, Last) Wilhelm Cramer				18. Mother's Name (First, Middle, Maiden Surname) Matilda Rouschel				
	19a. Informant's Name/Relationship (Type, Print) Debra Kennedy/Daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 Glenora Place, Bel Air, MD 21014				
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <i>Bel Air Memorial Gar.</i>			20b. Place of Disposition (Name of cemetery, crematory or other place) Bel Air Memorial Gar.		Date 04/18/2007	20c. Location - City or Town, State Bel Air, MD		
	21. Signature of Funeral Service Licensee Brian D. Lewis per DVR								
	22. Name and Address of Facility Schimunek Funeral Home of Bel Air Inc., 610 W. Macphail Rd., Bel Air, MD								
Physician /Medical Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <i>CVA</i>								Approximate Interval Between Onset and Death <i>Weeks</i>
	23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown								
	23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) <i>Unknown</i>								
	23d. Date of delivery Month Day Year								
Medical Certification: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Normal pressure hydrocephalus</i>								
	23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown								
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
	26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide								
	28a. Date of Injury (Month, Day, Year) <input type="checkbox"/> 28b. Time of Injury <i>M</i> <input type="checkbox"/> Yes <input type="checkbox"/> No								
	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No								
	28d. Describe how injury occurred								
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)								
	28f. Location (Street and Number or Rural Route Number, City or Town, State)								
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
	29b. Signature and title of certifier Wendy Klose								
	29c. License number D3129-1								
	29d. Date signed (Month, Day, Year) 6/18/07								
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Wendy Klose mo 6701 N Charles St Suite 4202 Towson MD 21204</i>								
	31. Date filed (Month, Day, Year) JUN 18 2007								
	32. Registrar's Signature <i>Wendy Klose</i>								

Baltimore, Maryland 21215-0036

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit slip.

Medical Certification: To Be Completed by Physician/Medical Examiner

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 12130

1 - For
State
RegistrarPhysician
/Medical
Examiner

		1. Decedent's Name (First, Middle, Last)				2. Date of Death		3. Time of Death	
		Carl Anthony Kurek				Month Day Year		Year	
		4a. Facility Name (If not institution, give street and number) FRANKLIN Square Hospital				4b. City, Town, or Location of Death Rosedale		4c. County of Death Baltimore	
Funeral Director		5. Social Security Number 216-20-2786	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 80 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) June 3, 1926	9. Birthplace (State or Foreign Country) Maryland	
To Be Completed by Funeral Director		Usual Residence of Decedent 10a. State Maryland				10b. County Baltimore 10c. City, Town or Location Essex			
		10e. Street and Number 1931 Sue Creek Drive				10f. Zip Code 21221		10g. Citizen of What Country? U. S. A.	
		11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No 1944 - If Yes, Give Year or Dates: 1946		13. Was Decedent of Hispanic Origin? (Specify Yes or No) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10th		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Tool & Dye Maker		16b. Kind of Business/Industry Can Company			
		17. Father's Name (First, Middle, Last) Frank Kurek				18. Mother's Name (First, Middle, Maiden Surname) Mary Bier			
		19a. Informant's Name/Relationship (Type, Print) Rita Kurek (Wife)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1931 Sue Creek Dr., Essex, Maryland 21221					
		20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) ► Bayview Crematory		20b. Place of Disposition (Name of cemetery, crematory or other place) Bayview Crematory		Date 04/14/2007	20c. Location - City or Town, State Baltimore, Maryland		
		21. Signature of Funeral Service Licensee ► Brian C. Muller		22. Name and Address of Facility Schimunek Funeral Homes 9705 Belair Road, Baltimore, Maryland 21236					
Physician /Medical Examiner		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				Approximate Interval Between Onset and Death Ruptured Abdominal Aneurysm			
		a. Due to (or as a consequence of): Cardiac Arrest							
		b. Due to (or as a consequence of):							
		c. Due to (or as a consequence of):							
		d. Due to (or as a consequence of):							
		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome pf pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year			
		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Ruptured AAA				23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
		25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA		26. Place of Death Check one Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred		
				28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
		29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
		29b. Signature and title of certifier ► Robert M. D.		29c. License number D22481		29d. Date signed (Month, Day, Year) 4/13/07			
		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) J. BAJI George MD 900 Franklin Square Drive Baltimore MD 21237							
State Registrar		31. Date filed (Month, Day, Year) APR 17 2007	32. Registrar's Signature James B. Muller						

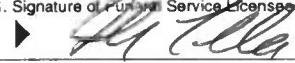
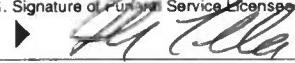
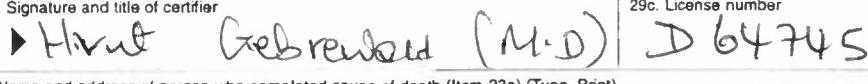
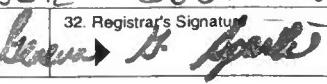
KUREK, Carl Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760, A

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene
1- For State Amend #7.8.perME, g866, 4/25/07 TT Certificate of Death
Registrar Reg. No. 2007 12131

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) GEORGE KEEN				2. Date of Death Month 04 Day 14 Year 2007	3. Time of Death 2:40 p M					
	4a. Facility Name (If not institution, give street and number) Good Samaritan Hospital				4b. City, Town, or Location of Death Baltimore		4c. County of Death				
Funeral Director	5. Social Security Number 213-26-9259		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 78 77 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Hours	8. Date of Birth (Month, Day, Year) June 4, 1928	9. Birthplace (State or Foreign Country) Maryland			
	Usual Residence of Decedent 10a. State Maryland 10b. County Baltimore				10c. City, Town or Location Baltimore			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
To Be Completed by Funeral Director	10e. Street and Number 4501 Ridge Road				10f. Zip Code 21236		10g. Citizen of What Country? U. S. A.				
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: 1928-1945			13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: White			14. Race - American Indian, Black, White, etc. Specify: White			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 6th			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Equipment Operator			16b. Kind of Business/Industry Coal Company				
	17. Father's Name (First, Middle, Last) Arthur Alexander Keen				18. Mother's Name (First, Middle, Maiden Surname) Elsie Culbertson						
	19a. Informant's Name/Relationship (Type, Print) Margaret L. Keen (Wife)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4501 Ridge Road, Baltimore, Maryland 21236						
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) 				20b. Place of Disposition (Name of cemetery, crematory or other place) Gardens of Faith		Date 04/19/2007	20c. Location - City or Town, State Baltimore, Maryland			
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Schimunek Funeral Homes 9705 Belair Road, Baltimore, Maryland 21236						
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sudden Cardiorespiratory Arrest Due to (or as a consequence of): Sepsis Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last { a. Sudden Cardiorespiratory Arrest Due to (or as a consequence of): Sepsis Due to (or as a consequence of): c. Due to (or as a consequence of): d. _____								Approximate Interval Between Onset and Death		
Physician /Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown				23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown <input type="checkbox"/> Other (specify) _____				23d. Date of delivery Month Day Year		
Medical Certification: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Hypertension Diabetes Mellitus				23e. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown						
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) _____				23f. Did alcohol contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide				28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	28e. Place of Injury At home, farm, street, factory, office building, etc. (Specify) At home				28f. Location (Street and Number or Rural Route Number, City or Town, State) Baltimore, Maryland 21236						
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29c. License number D 64745				29d. Date signed (Month, Day, Year) 04/14/2007		
	29b. Signature and title of certifier 				29c. License number D 64745				29d. Date signed (Month, Day, Year) 04/14/2007		
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hirut Gebrewold S601 Loch Raven Boulevard, Baltimore MD 21239										
State Registrar	31. Date filed (Month, Day, Year) APR 17 2007		32. Registrar's Signature 								

Baltimore, Maryland 21215-0036

Permit: Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a show any injury or other traumatic event, the Medical Examiner must be notified.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2007 12132

Reg. No.

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Joan Marie Knoch							2. Date of Death Month Day Year April 8, 2007	3. Time of Death 6:25 PM M	
	4a. Facility Name (If not institution, give street and number) Keswick Multi Medical			4b. City, Town, or Location of Death Baltimore			4c. County of Death			
Funeral Director	5. Social Security Number 218-28-9872	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 77 Yrs.	If Under 1 Year Months 0	If Under 24 hrs. Days 0	Hours 0	Min. 0	8. Date of Birth (Month, Day, Year) June 17, 1929	9. Birthplace (State or Foreign Country) Maryland	
	Usual Residence of Decedent 10a. State MD 10b. County Baltimore 10c. City, Town or Location Towson								10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number 528 Stevenson Lane				10f. Zip Code 21286			10g. Citizen of What Country? USA			
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: 1945-1948		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: white			14. Race - American Indian, Black, White, etc.			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 4		unk			16b. Kind of Business/Industry Walters Art Gallery			
17. Father's Name (First, Middle, Last) Charles Henry Knoch				18. Mother's Name (First, Middle, Maiden Surname) Helen Phoebe Gottsman						
19a. Informant's Name/Relationship (Type, Print) Robert Skeen/attorney				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1200 Linden Green Baltimore, MD 21217						
20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place)		Date			20c. Location - City or Town, State			
21. Signature of Funeral Service Licensee Ronald S. Wade, Director				22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201						
23a. Part I. Enter the disease/ or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) End-stage Dementia										Approximate Interval Between Onset and Death years
<p>a. Due to (or as a consequence of): End-stage Dementia</p> <p>b. Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. _____</p>										
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last										
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown						23d. Date of delivery Month Day Year		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Dementia Urinary tract infection										23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
29b. Signature and title of certifier W.A. Riley, MD				29c. License number 025205			29d. Date signed (Month, Day, Year) April 9, 2007			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) W.A. Riley 6301 N. Charles St. Balt. Md 21205		31. Date filed (Month, Day, Year) APR 17 2007								
32. Registrar's Signature James B. Frank										

Baltimore, Maryland 21215-0036

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified immediately.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 12133

1- For State Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) David Kinsley							2. Date of Death Month APRIL Day 12 Year 2007	3. Time of Death 6:00 AM	
	4a. Facility Name (If not institution, give street and number) The Johns Hopkins Hospital			4b. City, Town, or Location of Death Baltimore City			4c. County of Death			
Funeral Director	5. Social Security Number 216-46-1535	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 51 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Hours	8. Date of Birth (Month, Day, Year) May 16, 1955	9. Birthplace (State or Foreign Country) MD			
To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State MD 10b. County Howard			10c. City, Town or Location Ellicott City				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
	10e. Street and Number 9810 Northbrook Court			10f. Zip Code 21042			10g. Citizen of What Country? USA			
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 7		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Senior Litigation Attorney		16b. Kind of Business/Industry Legal					
	17. Father's Name (First, Middle, Last) Robert Elliott Kinsley			18. Mother's Name (First, Middle, Maiden Surname) Mary Young						
	19a. Informant's Name/Relationship (Type, Print) Mrs. Connie Kinsley (Spouse)			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9810 Northbrook Court Ellicott City, MD 21042						
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) All County Cremation			20b. Place of Disposition (Name of cemetery, crematory or other place) All County Cremation		Date 4/13/2007	20c. Location - City or Town, State Sykesville, MD			
	21. Signature of Funeral Service Licensee ► Brian L. Haiget			22. Name and Address of Facility HAIGHT FUNERAL HOME & CHAPEL, PA (Box 195) Sykesville, MD 21784 (410)-795-1400						
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sepsis								Approximate Interval Between Onset and Death 24 hours	
	23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown									
	23c. If yes, outcome pf pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) 9. Unknown								23d. Date of delivery Month Day Year	
Medical Certification: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
									24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred			
			28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)					
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
	29b. Signature and title of certifier ► Priya Makadia / Medical Doctor		29c. License number Res - 000			29d. Date signed (Month, Day, Year) April 12, 2007				
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PRIYA MAKADIA, The Johns Hopkins Hospital, 600 North Wolfe Street, Baltimore, Maryland, 21205									
State Registrar	31. Date filed (Month, Day, Year) APR 17 2007		32. Registrar's Signature ► [Signature]							

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division or Vital Records, P.O. Box 68760, *EC*

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 12134

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Eleanor I. Kapraun							2. Date of Death Month Day Year April 14, 2007	3. Time of Death 1:15am M						
	4a. Facility Name (If not institution, give street and number) Lorien Nursing Home			4b. City, Town, or Location of Death Mt. Airy			4c. County of Death Carroll								
Funeral Director	5. Social Security Number 216-18-7934	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 98 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) Apr 1, 1909	9. Birthplace (State or Foreign Country) MD								
To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State MD 10b. County Carroll 10c. City, Town or Location Mt. Airy 10d. Inside City Limits 1 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No														
	10e. Street and Number 713 Midway Avenue			10f. Zip Code 21771			10g. Citizen of What Country? USA								
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: 7		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: White			14. Race - American Indian, Black, White, etc. White							
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 7 College (1-4 or 5+) College			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker			16b. Kind of Business/Industry Domestic								
	17. Father's Name (First, Middle, Last) David B. Myers				18. Mother's Name (First, Middle, Maiden Surname) Edna Tawney										
	19a. Informant's Name/Relationship (Type, Print) Ms. Janet Kapraun (Daughter)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 656 Morning Glory Drive Hanover, PA 17331										
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) All County Cremation			20b. Place of Disposition (Name of cemetery, crematory or other place) All County Cremation		Date 4/17/07	20c. Location - City or Town, State Sykesville, MD								
	21. Signature of Funeral Service Licensee Brian L. Haugst														
	22. Name and Address of Facility HIGHT FUNERAL HOME & CHAPEL, PA (Box 195) Sykesville, MD 21784 (410)-795-1400														
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) RENAL Failure Due to (or as a consequence of): Failure to Thrive Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Cachexia, anoxia Due to (or as a consequence of): Tumobility Syndrome Approximate Interval Between Onset and Death yr														
Medical Certification: To Be Completed by Physician/Medical Examiner	23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown									23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year		
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Sarcopenia									23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown					
										24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)												
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide			28a. Date of Injury (Month, Day Year)		28b. Time of Injury	28c. Injury at Work? M 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred							
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)									28f. Location (Street and Number or Rural Route Number, City or Town, State)					
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									29c. License number D54749					
	29b. Signature and title of certifier Allen Reilly MD									29d. Date signed (Month, Day, Year) April 16, 2007					
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Allen Reilly, MD 801 Fall House Ave, D-1, Frederick, Md 21701									31. Date filed (Month, Day, Year) APR 17 2007					
	32. Registrar's Signature John L. Spangler														

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 12135

1- For
State
RegistrarPhysician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Joseph M. Lambrecht

2. Date of Death

Month April Day 11 Year 2007

3. Time of Death

11:14 AM

4a. Facility Name (If not institution, give street and number)

University of Maryland Medical Center

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

173-22-9866

6. Sex

 M F

7. Age (In yrs. last birthday)

77

Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

Feb. 4, 1930

9. Birthplace (State or Foreign Country)

Pennsylvania

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
 Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

Usual Residence of Decedent

10a. State Maryland

10b. County Howard

10c. City, Town or Location Columbia

10d. Inside City Limits

 Yes No

10e. Street and Number

5424 Storm Drift

21045

10g. Citizen of What Country?

U.S.A.

11. Marital Status

 Never Married Married
 Widowed Divorced

12. Was Decedent Ever in U.S. Armed Forces?

 Yes No
If Yes, Give Year or Dates: 1948-1952

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
 Yes No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

Ford Mechanic

16b. Kind of Business/Industry

Ford Corporation

17. Father's Name (First, Middle, Last)

Josef Lambrecht

18. Mother's Name (First, Middle, Maiden Surname)

Margaret Kersche

19a. Informant's Name/Relationship (Type, Print)

Frances Lambrecht (Wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5424 Storm Drift Columbia, MD 21045

20a. Method of Disposition

 Burial Cremation Removal from State
 Donation Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metro Crematory

Date

4-17-2007

20c. Location - City or Town, State

Catonsville, MD

21. Signature of Funeral Service Licensee

▶ WMSK. Haldeman M01050

22. Name and Address of Facility

Witzke Funeral Homes, Inc.
5555 Twin KNolls Toad Columbia, MD 21045

Approximate Interval Between Onset and Death

Physician
/Medical
Examiner

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Pulmonary Embolism

Due to (or as a consequence of):

b. Deep Venous Thrombosis

Due to (or as a consequence of):

c. Prostate Adenocarcinoma

Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?
 Yes No
 Unknown23c. If yes, outcome pf pregnancy
 Live birth Fetal death
 Pregnant at time of death
 Unknown

3

Ectopic pregnancy

5

Other (Specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

 Yes No Probably Unknown

25. Was case referred to medical examiner?

 Yes No

26. Place of Death (Check only one)

Hospital: Inpatient ER/Outpatient DOA Other: Nursing Home Residence Other (Specify)

27. Manner of Death

 Natural
 Accident
 Suicide
 Homicide5 Pending investigation6 Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1

 Yes No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

▶ m.d. Medicine Fellow DOD65421 April 11th, 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Christa Tokarsky, MD 22 S. Greene St. Baltimore, MD 21201

31. Date filed (Month, Day, Year)

APR 17 2007

32. Registrar's Signature

▶ Christa Tokarsky

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

6+1

State
Registrar

Division or Vital Records, P.O. Box 68760,

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
 Important: If item 27 is marked other than "natural", or items 23a or 28e-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

		Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.										
		State of Maryland / Department of Health and Mental Hygiene										
		Certificate of Death										
1- For State Registrar		Reg. No. 2007 12136										
Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last)			2. Date of Death			3. Time of Death					
	MILDRED LAGROSSA			Month April	Day 13	Year 2007	12:07 PM					
Funeral Director	4a. Facility Name (If not institution, give street and number)			4b. City, Town, or Location of Death			4c. County of Death					
	Ellicott City Health & Rehab. Ctr			Ellicott City			Howard					
Usual Residence of Decedent		10a. State Maryland		10b. County Howard		10c. City, Town or Location Elkridge				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
10e. Street and Number		10f. Zip Code 21075		10g. Citizen of What Country? USA								
11. Marital Status		12. Was Decedent Ever in U.S. Armed Forces?			13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)			14. Race - American Indian, Black, White, etc.				
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:			1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			Specify: White				
15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)			16b. Kind of Business/Industry							
Elementary/Secondary (0-12) 12		College (1-4 or 5+) Waitress			Restaurant							
17. Father's Name (First, Middle, Last)		18. Mother's Name (First, Middle, Maiden Surname)										
Walter Tamm		Murphy Broughman										
19a. Informant's Name/Relationship (Type, Print)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)										
Sharon Hayes- daughter		3216 Wheaton Way, Ellicott City, MD 21043										
20a. Method of Disposition		20b. Place of Disposition (Name of cemetery, crematory or other place)			Date			20c. Location - City or Town, State				
1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		Metro Crematory			April 16, 2007			Catonsville, MD				
21. Signature of Funeral Service Licensee		22. Name and Address of Facility Gary L. Kaufman Funeral Home at MMP, INC. 7250 Washington Blvd., Elkridge, MD 21075										
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.												
Immediate Cause (Final disease or condition resulting in death) METASTATIC BLADDER CANCER												
Approximate Interval Between Onset and Death												
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last												
<p>a. Due to (or as a consequence of): RENAL FAILURE</p> <p>b. Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. Due to (or as a consequence of):</p>												
IF FEMALE:		23c. If yes, outcome of pregnancy			23d. Date of delivery							
23b. Was decedent pregnant in the past 12 months?		1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown			Month Day Year							
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.												
23e. Did tobacco use contribute to the cause of death?												
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown												
25. Was case referred to medical examiner?		Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA			Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			26. Place of Death (Check only one)				
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No												
27. Manner of Death		28a. Date of Injury (Month, Day, Year)			28b. Time of Injury			28c. Injury at Work?			28d. Describe how injury occurred	
1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined								M 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No				
3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)									28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one)		29b. Signature and title of certifier			29c. License number			29d. Date signed (Month, Day, Year)				
1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		<i>Walter Lamm</i>			D53987			April 13, 2007				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)		31. Date filed (Month, Day, Year)			32. Registrar's Signature			PL, SUITE 3G				
BALTIMORE MD 21201		APR 17 2007			<i>James B. Gaskins</i>							

07-02753

Christian Micha Luciano

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2007 12137

1- For State
Registrar**Physician/
Medical Examiner**

1. Decedent's Name (First, Middle, Last) Christian M. Luciano				2. Date of Death Month Day Year April 11, 2007	3. Time of Death 0816 hrs
4a. Facility Name (if not institution, give street and number) Interstate 270 near Park Mills Road			4b. City, Town, or Location of Death Frederick		4c. County of Death Frederick
5. Social Security Number 167-60-1754	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 28 Yrs.	If Under 1 Year Months Days Hours Min.	8. Date of Birth (MM/DD/YYYY) Feb. 16, 1979	9. Birthplace (State or Foreign Country) PA

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. If Item 27 is marked other than "natural", or items 2a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, MD 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed

Within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit

**Funeral
Director****To Be Completed by Funeral Director**

10a. State PA	10b. County Northampton	10c. City, Town or Location North Catasauqua	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
10e. Street and Number 840 Willow Drive		10f. Zip Code 18032	10g. Citizen of What Country? United States
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	14. Race - American Indian, Black, White, etc. White
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 2		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Tile Worker	16b. Kind of Business/Industry Flooring Industry
17. Father's Name (First, Middle, Last) Michael A. Luciano		18. Mother's Name (First, Middle, Maiden Surname) Sheila Mosser	
19a. Informant's Name/Relationship (Type, Print) Michael A. Luciano - Father		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 840 Willow Drive, North Catasauqua, PA 18032	
20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input checked="" type="checkbox"/> Removal from State		20b. Place of Disposition (Name of cemetery, crematory, or other place) Allen Union Cemetery	Date 4-18-2007
21. Signature of Funeral Service Licensee <i>Michael A. Luciano</i>		22. Name and Address of Facility Ambrose Funeral Home, Inc. 1328 Sulphur Spring Rd., Arbutus, MD 21227	

**Physician
/Medical
Examiner****Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.		Approximate Interval Between Onset and Death	
Immediate Cause (Final disease or condition resulting in death) a. Chest injuries Due to (or as a consequence of):			
b. _____ Due to (or as a consequence of):			
c. _____ Due to (or as a consequence of):			
d. _____			
<input type="checkbox"/> UNPENDED	<input type="checkbox"/> AMENDED		
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) _____ 9 <input type="checkbox"/> Unknown	23d. Date of delivery Month Day Year
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
		24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> N	24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other: Scene		
27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input checked="" type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide	28a. Date of Injury (Month, Day, Year) Apr 11, 2007	28b. Time of Injury 0809 hrs	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Major Road / Highway		28d. Describe how injury occurred Driver auto auto collision	
29a. Certifier 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29e. Location (Street and Number or Rural Route Number, City or Town, State) Interstate 270 near Park Mills Road, Frederick, MD	
29b. Signature and title of certifier <i>Zabiullah Ali</i>		29c. License number O.C.M.E.	29d. Date signed (Month, Day, Year) April 12, 2007
30. Name and address of person who completed cause of death (Item 23a) Zabiullah Ali, M.D. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201			

**State
Registrar**

31. Date filed (Month, Day, Year) APR 17 2007	32. Registrar's Signature <i>[Signature]</i>
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ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2007 12138

Certificate of Death

Reg. No.

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) DOROTHY POWELL LEACH							2. Date of Death Month Day Year APRIL 13, 2007	3. Time of Death 7:00a M
	4a. Facility Name (If not institution, give street and number) BRIGHTON GARDENS			4b. City, Town, or Location of Death CHEVY CHASE			4c. County of Death MONTGOMERY		
Funeral Director	5. Social Security Number 220-50-1313		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 95 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) 5/25/1911	9. Birthplace (State or Foreign Country) MARYLAND	
	Usual Residence of Decedent 10a. State MD		10b. County MONTGOMERY		10c. City, Town or Location CHEVY CHASE			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number 5555 FRIENDSHIP BLVD.		10f. Zip Code 20815			10g. Citizen of What Country? USA				
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: 1945			13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: White			14. Race - American Indian, Black, White, etc. Specify: WHITE	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) HOMEMAKER			16b. Kind of Business/Industry OWN HOME				
17. Father's Name (First, Middle, Last) EUGENE POWELL					18. Mother's Name (First, Middle, Maiden Surname) BESSIE EARHARDT				
19a. Informant's Name/Relationship (Type, Print) PATRICIA FISKE daughter		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4938 WESTERN AVENUE BETHESDA, MD 20816			Date 4/25/2007	20c. Location - City or Town, State PIKESVILLE, MD			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) DRUID RIDGE		20b. Place of Disposition (Name of cemetery, crematory or other place)							
21. Signature of Funeral Service Licensee RAMBURG		22. Name and Address of Facility HENRY W. JENKINS & SONS CO. 16924 YORK RD MONKTON, MD 21111							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) INANITION		23b. Due to (or as a consequence of): Dementia			Approximate Interval Between Onset and Death MONTHS				
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		23c. Due to (or as a consequence of): 			23d. Date of delivery Month Day Year 				
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year 				
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown				
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) 			23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown				
27. Manner of Death 1 Natural 5 Pending investigation 2 Accident 6 Could not be determined 3 Suicide 4 Homicide		28a. Date of Injury (Month, Day Year) 		28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No 	28d. Describe how injury occurred 			
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 			28f. Location (Street and Number or Rural Route Number, City or Town, State) 				
29b. Signature and title of certifier JM CONNELL		29c. License number D39456			29d. Date signed (Month, Day, Year) 4/16/07				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. LILA T. MCCONNELL 5530 WISCONSIN AVE. SUITE 1400 MARYLAND 20815		32. Registrar's Signature Laura B. Aponte			31. Date filed (Month, Day, Year) APR 17 2007				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 12139

1- For
State
RegistrarPhysician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Edmund William Lubinski	APRIL 10 2007	9:30 P M
4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
GREATER BALTIMORE MEDICAL CENTER	TOWSON	BALTIMORE

Funeral
Director

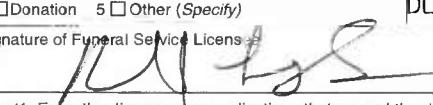
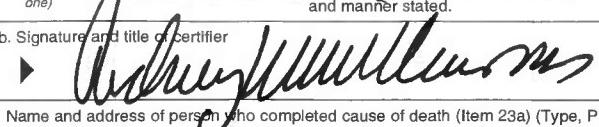
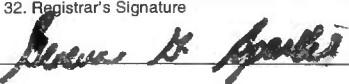
To Be Completed by Funeral Director

LUBINSKI Edmund
Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician
/Medical
Examiner

5. Social Security Number	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 93 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Sept. 6, 1913	9. Birthplace (State or Foreign Country) Maryland	
Usual Residence of Decedent			10a. State Md. 10b. County Baltimore			10c. City, Town or Location Lutherville	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
10e. Street and Number 102 Ardoon Road			10f. Zip Code 21093			10g. Citizen of What Country? USA	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 5+		16b. Kind of Business/Industry Appraiser		Real Estate	
17. Father's Name (First, Middle, Last) Stanislaus Lubinski			18. Mother's Name (First, Middle, Maiden Surname) Sophie Lechert				
19a. Informant's Name/Relationship (Type, Print) Mrs. Margaret Lubinski/ Wife			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 102 Ardoon Rd. Lutherville, Md. 21093				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Dulaney Valley Mem.			Date 4-18-07	20c. Location - City or Town, State Timonium, Md.
21. Signature of Funeral Service Licensee 			22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204			Approximate Interval Between Onset and Death 3 d	
<p>23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.</p> <p>Immediate Cause (Final disease or condition resulting in death)</p> <p><i>Pulmonary embolism</i></p> <p>Sequentially list conditions, if any, leading to the immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</p> <p>a. Due to (or as a consequence of):</p> <p>b. Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. Due to (or as a consequence of):</p>							
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome pf pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown				23d. Date of delivery Month Day Year	
<p>Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.</p> <p><i>Bladder cancer</i> <i>dementia</i> <i>Parkinson's</i></p>							
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred		
		28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
<p>29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.</p> <p>29b. Signature and title of certifier </p> <p>29c. License number D39099</p> <p>29d. Date signed (Month, Day, Year) April 12, 2007</p>							
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rodney Williams MD GBMC 6601 N. Charles St. Baltimore, Md. 21204							
31. Date filed (Month, Day, Year) APR 17 2007		32. Registrar's Signature 					

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transit

Division or Vital Records, P.O. Box 68760, MD

within 24 hours after death.
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 12140

1 - For State Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Ethel Jean Leberknight						2. Date of Death Month Day Year April 10, 2007	3. Time of Death 4:45 a M
	4a. Facility Name (If not institution, give street and number) Ruxton Health and Rehabilitation			4b. City, Town, or Location of Death Pikesville			4c. County of Death Baltimore	
Funeral Director	5. Social Security Number 210-09-0151	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 94 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) July 31, 1912	9. Birthplace (State or Foreign Country) Pennsylvania	
To Be Completed by Funeral Director	10a. State MD 10b. County Baltimore 10c. City, Town or Location Perry Hall						10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	10e. Street and Number 4206 Hollow Spring Lane			10f. Zip Code 21236			10g. Citizen of What Country? USA	
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give X Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker			16b. Kind of Business/Industry Own Home		
	17. Father's Name (First, Middle, Last) John James Coulter				18. Mother's Name (First, Middle, Maiden Surname) Della M. Robinson			
	19a. Informant's Name/Relationship (Type, Print) Paul D. Leberknight- Son			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4206 Hollow Spring Lane Perry Hall, MD 21236				
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Meadowridge Cemetery			Date 4/13/07	20c. Location - City or Town, State Baltimore, Maryland	
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Charles S Zeiler & Son 6224 Eastern Avenue Baltimore, MD 21224			
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Underlying Dementia Approximate Interval Between Onset and Death							
	23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown							
	23c. If yes, outcome pf pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____							
	23d. Date of delivery Month Day Year							
Medical Certification: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
	23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown							
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No							
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
	26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide							
	28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 28d. Describe how injury occurred							
	28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)							
	29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
	29b. Signature and title of certifier 							
	29c. License number DA7683 29d. Date signed (Month, Day, Year) 4/11/07							
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Raymond Miller 25 Main Street Suite 202 Pikesville MD 21236							
State Registrar	31. Date filed (Month, Day, Year) APR 17 2007		32. Registrar's Signature 					

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 12161

1 - For State Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) GRACE LANDAU							2. Date of Death Month Day Year APRIL 12 2007			3. Time of Death 23:30 M					
	4a. Facility Name (If not institution, give street and number) NORTHWEST HOSPITAL			4b. City, Town, or Location of Death RANDALLSTOWN				4c. County of Death BALTIMORE COUNTY								
Funeral Director	5. Social Security Number 143-18-8822	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 83 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) May 9, 1923	9. Birthplace (State or Foreign Country) New Jersey									
To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State Maryland 10b. County Baltimore City 10c. City, Town or Location Baltimore City										10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No					
	10e. Street and Number 6203 Elmbank Ave.				10f. Zip Code 21209			10g. Citizen of What Country? U.S.A.								
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: White			14. Race - American Indian, Black, White, etc. White								
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Homemaker		16b. Kind of Business/Industry Own Home											
	17. Father's Name (First, Middle, Last) Wilfred Rausenberger					18. Mother's Name (First, Middle, Maiden Surname) Helen Reitsma										
	19a. Informant's Name/Relationship (Type. Print) Ms. Deborah Weimer Daughter			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6203 Elmbank Ave. Baltimore, Maryland 21209												
Physician /Medical Examiner	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Bayview Crematory			Date 04/14/07	20c. Location - City or Town, State Baltimore, MD								
Medical Certification: To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee Kennedy Gabregiorgish, MD			22. Name and Address of Facility Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043												
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) PNEUMONIA Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last a. Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):										Approximate Interval Between Onset and Death					
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown			23c. If yes, outcome pf pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify)			23d. Date of delivery Month Day Year									
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown					
											24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)												
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide			28a. Date of Injury (Month, Day Year) M			28b. Time of Injury M	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred							
	5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined			28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State) At home, farm, street, factory, office building, etc. (Specify)									
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.			29c. License number BG-9427394			29d. Date signed (Month, Day, Year) APRIL 12, 2007									
	29b. Signature and title of certifier Kennedy Gabregiorgish, MD			32. Registrar's Signature Debbie B. Speer												
	31. Date filed (Month, Day, Year) APR 17 2007			32. Registrar's Signature Debbie B. Speer												

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit once.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

State of Maryland / Department of Health
1- For State Amend #20b-c, per FH, G866, 4/17/07 TT Certificate of Death
Registrar

Reg. No. 200 **Date** 2-4-2

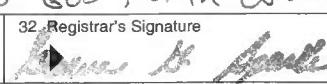
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 12143

1- For State Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) SHAWN			2. Date of Death Month APRIL Day 14 Year 2007		3. Time of Death 18:58 P M		
	4a. Facility Name (If not institution, give street and number) The Johns Hopkins Hospital			4b. City, Town, or Location of Death Baltimore City		4c. County of Death		
Funeral Director	5. Social Security Number 217-84-0535	6. Sex XXM	7. Age (In yrs. last birthday) 44 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days Hours Min.	8. Date of Birth (Month, Day, Year) JULY 6, 1962	9. Birthplace (State or Foreign Country) MD	
To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State MD 10b. County BALTIMORE 10c. City, Town or Location TURNER STATION						10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No X	
	10e. Street and Number 207 MAIN STREET			10f. Zip Code 21222		10g. Citizen of What Country? USA		
	11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: BLACK			14. Race - American Indian, Black, White, etc. Specify: BLACK	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) FACTORY WORKER		16b. Kind of Business/Industry BOX FACTORY			
	17. Father's Name (First, Middle, Last) ERNEST MOSS			18. Mother's Name (First, Middle, Maiden Surname) MARGARET GREGORY				
	19a. Informant's Name/Relationship (Type, Print) MARGARET MOSS/MOTHER			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 207 MAIN STREET BALTIMORE, MARYLAND 21217				
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) ARBUSUS MEMORIAL PK.		Date 4-21-07	20c. Location - City or Town, State BALTIMORE, MARYLAND	
	21. Signature of Funeral Service Licensee 			22. Name and Address of Facility JAMES A. MORTON & SONS F.H., INC. 1701-31 LAURENS ST. BALTIMORE, MARYLAND 21217				
Physician /Medical Examiner	23a. Part I Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Kidney Failure Approximate Interval Between Onset and Death 10 years							
	a. Due to (or as a consequence of): Cytomegalovirus fulminant infection b. Due to (or as a consequence of): Septic shock c. Due to (or as a consequence of): d.							
	23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown			23c. If yes, outcome pf pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year	
Medical Certification: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
	23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown							
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No							
	24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No							
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred		
			28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
	29b. Signature and title of certifier 		29c. License number RES-000		29d. Date signed (Month, Day, Year) April 14 2007			
Medical Certification: To Be Completed by Physician/Medical Examiner	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JOSEPH M. FUENTES 603 North Wolfe Street Baltimore MD 21287-9106							
State Registrar	31. Date filed (Month, Day, Year) APR 17 2007		32. Registrar's Signature 					

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

12

Important: If item 27 is marked other than "natural"; or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

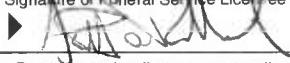
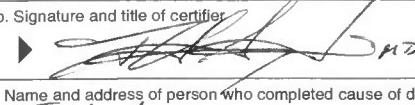
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 12144

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) ROBERT S MARSH				2. Date of Death Month 04 Day 12 Year 2007	3. Time of Death 7:58 PM			
	4a. Facility Name (If not institution, give street and number) BALTIMORE WASHINGTON MEDICAL CENTER		4b. City, Town, or Location of Death GLEN BURNIE		4c. County of Death ANNE ARUNDEL				
Funeral Director	5. Social Security Number 241-34-9852	6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) 79 Yrs.	If Under 1 Year Months 0	If Under 24 Hrs. Days 0	8. Date of Birth (Month, Day, Year) Oct. 22, 1927	9. Birthplace (State or Foreign Country) North Carolina		
	Usual Residence of Decedent 10a. State Maryland 10b. County Anne Arundel		10c. City, Town or Location Millersville				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
To Be Completed by Funeral Director	10e. Street and Number 8262 Woods Rd.			10f. Zip Code 21108		10g. Citizen of What Country? United States			
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: WW II		13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Steel Worker		16b. Kind of Business/Industry Steel Industry			
	17. Father's Name (First, Middle, Last) Reidus Gustus Marsh				18. Mother's Name (First, Middle, Maiden Surname) Emma Biggerstaff				
	19a. Informant's Name/Relationship (Type, Print) Lana Harrison / Niece			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11 Crescent Lane, Elkton, Maryland 21921					
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input checked="" type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Cleveland Mem. Park		Date April 16, 2006	20c. Location - City or Town, State North Cliffside, Carolina		
	21. Signature of Funeral Service Licensee 			22. Name and Address of Facility Kirkley-Ruddick Funeral Home, P.A. 421 Crain Hwy., S.E., Glen Burnie, MD 21061					
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) PROBABLE VENTRICULAR ARRHYTHMIA Due to (or as a consequence of): Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last CONGESTIVE HEART FAILURE Due to (or as a consequence of): CORONARY ARTERY DISEASE Due to (or as a consequence of): d.							Approximate Interval Between Onset and Death 1 YEAR	
Medical Certification: To Be Completed by Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown			23c. If yes, outcome pf pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify)			23d. Date of delivery Month Day Year		
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. HYPERTENSION THROMBOCYTOPENIA							23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown	
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide			28a. Date of Injury (Month, Day Year) 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined	28b. Time of Injury M	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred		
				28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) At home		28f. Location (Street and Number or Rural Route Number, City or Town, State) GLEN BURNIE 21061			
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.			29c. License number D 58914					
	29b. Signature and title of certifier 			29d. Date signed (Month, Day, Year) APRIL 13, 2007					
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) J. H. AYALA, MD 1417 MADISON PARK DRIVE GLEN BURNIE 21061			31. Date filed (Month, Day, Year) APR 17 2007					
State Registrar	32. Registrar's Signature 			ORIGINAL					

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

to the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2007 12145

1- For
State
Registrar

Physician
/Medical
Examiner

Funeral
Director

To Be Completed by Funeral Director

McElwee Joseph
Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural" or items 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year		3. Time of Death
Joseph S. McElwee Jr.		04 14 2007		11:00 M
4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of Death		4c. County of Death
Franklin Square Hospital		Rosedale		Baltimore
5. Social Security Number		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 62 Yrs.	If Under 1 Year Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Oct. 10, 1944
10a. State MD		10b. County Harford	10c. City, Town or Location Joppa	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
10e. Street and Number 1412 Old Joppa Road		10f. Zip Code 21085		10g. Citizen of What Country? USA
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: 2 yrs	13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Driver		16b. Kind of Business/Industry UPS Company
17. Father's Name (First, Middle, Last) Joseph S. McElwee Sr.			18. Mother's Name (First, Middle, Maiden Surname) Florence Niedzwick	
19a. Informant's Name/Relationship (Type, Print) Cheryl McElwee /wife		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1412 Old Joppa Road Joppa MD 21085		
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Holly Hill Cemetery	Date 4/21/07	20c. Location - City or Town, State Baltimore MD
21. Signature of Funeral Service Licensee Peter R. Perez		22. Name and Address of Facility 300 Mace Ave. Baltimore MD Connally Funeral Home of Essex 21221		
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		Approximate Interval Between Onset and Death		
a. Lung Cancer Due to (or as a consequence of):				
b. _____ Due to (or as a consequence of):				
c. _____ Due to (or as a consequence of):				
d. _____				
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____ <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				
23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown				
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No
		28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Describe how injury occurred
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29c. License number D 0061789		
29b. Signature and title of certifier Lorraine Ofori-Awuaah, MD		29d. Date signed (Month, Day, Year) APRIL 15, 2007		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LORRAINE OFORI-AWUAH, MD 9000 Franklin Sq. Dr. Baltimore, Md. 21237		32. Registrar's Signature Lorraine Ofori-Awuaah		
31. Date filed (Month, Day, Year) APR 17 2007		32. Registrar's Signature		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2007 12146

1- For State Registrar

Physician/
Medical Examiner

Reg. No.

1. Decedent's Name (First, Middle, Last)

Rami A. Martin

2. Date of Death

Month

Day

Year

April 9, 2007

3. Time of Death

1235 hrs

Funeral
Director

4a. Facility Name (if not institution, give street and number) University Hospital	4b. City, Town, or Location of Death Baltimore	4c. County of Death
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5. Social Security Number 212-02-9323	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 24 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (MM/DD/YYYY) 06 16 82	9. Birthplace (State or Foreign Country) MD
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Usual Residence of Decedent			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
10a. State MD	10b. County NA	10c. City, Town or Location Baltimore			

10e. Street and Number 2907 Windsor Ave	10f. Zip Code 21216	10g. Citizen of What Country? U.S.A.
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11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No specify: Specify: Black	14. Race - American Indian, Black, White, etc.
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15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th grade	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) na	16b. Kind of Business/Industry Unemployed
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17. Father's Name (First, Middle, Last) Randall Martin	18. Mother's Name (First, Middle, Maiden Surname) Deborah Morant
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19a. Informant's Name/Relationship (Type, Print) Deborah Martin-Mother	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2907 Windsor Ave, Baltimore, Md 21216
---	--

20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State	20b. Place of Disposition (Name of cemetery, crematory or other place) King Memorial Park	Date 4/18/07	20c. Location - City or Town, State Randallstown, Md
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21. Signature of Funeral Service Licensee Marilyn B. Kekic	22. Name and Address of Facility March F/H West 4300 Wabash Ave, Baltimore, Md 21215
---	--

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Multiple Gunshot Wounds Due to (or as a consequence of):	Approximate Interval Between Onset and Death
b. Due to (or as a consequence of):	
c. Due to (or as a consequence of):	
d. Due to (or as a consequence of):	

<input type="checkbox"/> UNPENDED	<input type="checkbox"/> AMENDED
IF FEMALE:	23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown
23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown	23d. Date of delivery Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown
_____	24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No
_____	24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No

25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA	26 Place of Death (Check only one) 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other:
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27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined 4 <input checked="" type="checkbox"/> Homicide	28a. Date of Injury (Month, Day, Year) FOUND: Apr 9, 2007	28b. Time of Injury FOUND: 0137 hrs	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	28d. Describe how injury occurred Subject shot
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Local Street	28f. Location (Street and Number or Rural Route Number, City or Town, State) Near 3619 Washington Avenue, Windsor Mill, MD			

29a. Certifier 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier Carol Allan	29c. License number O.C.M.E.	29d. Date signed (Month, Day, Year) April 10, 2007
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30. Name and address of person who completed cause of death (Item 23a) Carol Allan, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

31. Date filed (Month, Day, Year) APR 17 2007	32. Registrar's Signature Gwen B. Hall
--	---

ORIGINAL

Baltimore, MD 21215-0036

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 12147

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Emily Betty Marlow				2. Date of Death Month Day Year April 15, 2007	3. Time of Death 5:30P M		
	4a. Facility Name (If not institution, give street and number) 789 Paul Birch Drive		4b. City, Town, or Location of Death Crownsville		4c. County of Death Anne Arundel			
Funeral Director	5. Social Security Number 156-36-8624	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 62 Yrs.	If Under 1 Year Months 0	If Under 24 Hrs. Days 0	8. Date of Birth (Month, Day, Year) Jan. 9, 1945	9. Birthplace (State or Foreign Country) NJ	
	Usual Residence of Decedent 10a. State MD 10b. County Anne Arundel 10c. City, Town or Location Crownsville						10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
To Be Completed by Funeral Director	10e. Street and Number 789 Paul Birch Drive			10f. Zip Code 21032		10g. Citizen of What Country? U.S.A.		
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: 1945	13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: White	14. Race - American Indian, Black, White, etc.				
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Secretary	16b. Kind of Business/Industry Heating & Air Conditioning					
	17. Father's Name (First, Middle, Last) Foti			18. Mother's Name (First, Middle, Maiden Surname) Emily May				
	19a. Informant's Name/Relationship (Type, Print) Mr. Warren Marlow / Husband				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 789 Paul Birch Drive Crownsville, MD 21032			
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) Chesapeake Cremation		20b. Place of Disposition (Name of cemetery, crematory or other place) Chesapeake Cremation	Date April 19, 2007	20c. Location - City or Town, State Stevensville, MD			
	21. Signature of Funeral Service Licensee Delmar Shirey Molay		22. Name and Address of Facility Singleton Funeral Home, P.A.	1 Second Avenue SW Glen Burnie, MD 21061				
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Metastatic Colon cancer Approximate Interval Between Onset and Death 3 years							
Medical Certification: To Be Completed by Physician/Medical Examiner	23a. Part II. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Hypertension, Cardiovascular Disease							
	23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown				23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Unknown	23d. Date of delivery Month Day Year		
	23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown							
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No			
	25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA		26. Place of Death (Check only one) <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred		
			28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
	29b. Signature and title of certifier Jose Perez-Alvarez				29c. License number D41927		29d. Date signed (Month, Day, Year) 4.16.07	
	30. Name and address of person who completed cause of death (Item 29a) (Type, Print) Jose Perez-Alvarez, MD 3708 Mountain Rd, Hunt Valley, MD		31. Date filed (Month, Day, Year) APR 17 2007 32. Registrar's Signature John A. Steele					

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene
Certificate of Death

Reg. No. 2007 12148

1 - For State Registrar

Physician /Medical Examiner

Funeral Director

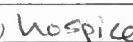
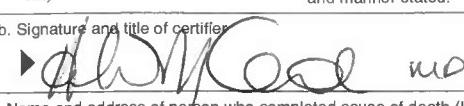
To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

		1. Decedent's Name (First, Middle, Last)		MILGROME		2. Date of Death Month Day Year	3. Time of Death	
		SOLOMON		TOWSON		APRIL 13 2007	4:10 P M	
		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of Death		4c. County of Death		
		HOSPICE OF BALTIMORE GILCHRIST CTR.				BALTIMORE		
		5. Social Security Number	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 104 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) 02/15/1903	9. Birthplace (State or Foreign Country) POLAND
		Usual Residence of Decedent						10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No X
		10a. State MD	10b. County N/A	10c. City, Town or Location BALTIMORE				
		10e. Street and Number 1111 PARK AVENUE #210		10f. Zip Code 21201		10g. Citizen of What Country? U.S.A.		
		11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever In U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE
		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) OWNER		16b. Kind of Business/Industry GROCERY		
		17. Father's Name (First, Middle, Last) ABRAHAM DAVID MILGROME		18. Mother's Name (First, Middle, Maiden Surname) FEIGE FENIK				
		19a. Informant's Name/Relationship (Type, Print) BARBARA COHEN / DAUGHTER		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3501 WOODVALLEY DRIVE - BALTIMORE, MD 21208				
		20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) FORBAND CEMETERY		20b. Place of Disposition (Name of cemetery, crematory or other place)		Date 04/15/2007	20c. Location - City or Town, State BALTIMORE, MD	
		21. Signature of Funeral Service Licensee 		22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208				
		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		debility		Approximate Interval Between Onset and Death days		
		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		{ a. Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):				
		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown <input type="checkbox"/> Other (specify) _____		23d. Date of delivery Month Day Year		
		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
		25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) 				
		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred	
				28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
		29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.						
		29b. Signature and title of certifier 		29c. License number D00519		29d. Date signed (Month, Day, Year) Apr. 14, 2007		
		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Helen M. Gordon 6565 N. Charles St, Baltimore MD 21204						
		31. Date filed (Month, Day, Year) APR 17 2007		32. Registrar's Signature 				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2007 12149

1- For State Amend #17, per FH, g866, 4/24/07 TT Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Peggy McCoy							2. Date of Death Month APRIL Day 11 Year 2007	3. Time of Death 0510 AM
	4a. Facility Name (If not institution, give street and number) St. Agnes Hospital			4b. City, Town, or Location of Death Baltimore			4c. County of Death		
Funeral Director	5. Social Security Number 218-48-1680		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 59 Yrs.	If Under 1 Year Months 0 Days 0	If Under 24 Hrs. Hours 0 Min. 0	8. Date of Birth (Month, Day, Year) 07/01/1947	9. Birthplace (State or Foreign Country) MD	
	10a. State MD		10b. County		10c. City, Town or Location Baltimore			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
To Be Completed by Funeral Director	10e. Street and Number 313 North Fulton Avenue			10f. Zip Code 21223			10g. Citizen of What Country? USA		
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. African American Specify: American	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) nursing assistant		16b. Kind of Business/Industry Baltimore City				
	17. Father's Name (First, Middle, Last) George E. Mitchell Elliott				18. Mother's Name (First, Middle, Maiden Surname) Virginia Sample				
	19a. Informant's Name/Relationship (Type, Print) Craig E. McCoy / Son			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 313 North Fulton Avenue; Baltimore, Maryland 21223					
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) Jewell Jones		20b. Place of Disposition (Name of cemetery, crematory or other place) Mount Zion Cemetery			Date 03/17/2007	20c. Location - City or Town, State Baltimore, Maryland		
	21. Signature of Funeral Service Licensee Jewell Jones		22. Name and Address of Facility Wylie Funeral Home, P.A. 638 North Gilmor Street; Baltimore, Maryland 21217						
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death 15 days 1 year 1 year years.
	<p>a. <i>Aspiration pneumonia</i> Due to (or as a consequence of): <i>Anoxic brain syndrome</i></p> <p>b. Due to (or as a consequence of): <i>Cardiac arrest</i></p> <p>c. Due to (or as a consequence of): <i>Coronary atherosclerosis</i></p>								
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome pf pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown <input type="checkbox"/> Other (specify) _____			23d. Date of delivery Month Day Year			
Medical Certification: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. _____ _____ _____								23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year) M	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred			
			28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier Lillian J. Hicken, M.D.						
			29c. License number D0004964			29d. Date signed (Month, Day, Year) April 11, 2007			
State Registrar	31. Date filed (Month, Day, Year) APR 17 2007		32. Registrar's Signature Jewell K. Apelle						

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,
McCoy, PEGGY

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM 200, C, PERIOD, 0060, 4/17/07, WS

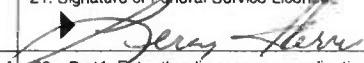
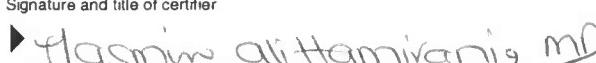
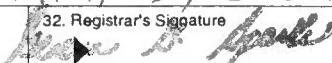
State of Maryland / Department of Health and Mental Hygiene

2007 12150

Certificate of Death

Reg. No.

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last)							2. Date of Death Month Day Year	3. Time of Death
	JOSEPH NORRIS							APRIL 12 2007	01:28 AM
Funeral Director	4a. Facility Name (If not institution, give street and number)				4b. City, Town, or Location of Death			4c. County of Death	
	THE JOHNS HOPKINS HOSPITAL				BALTIMORE CITY			N/A	
To Be Completed by Funeral Director	5. Social Security Number		6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year Months Days Hours Min.	8. Date of Birth (Month, Day, Year)		9. Birthplace (State or Foreign Country)	
	212-44-0779		1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	61 Yrs.		Oct. 25, 1945		Maryland	
	Usual Residence of Decedent		10a. State		10b. County		10c. City, Town or Location		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
	Maryland		N/A				Baltimore		
	10e. Street and Number		10f. Zip Code		10g. Citizen of What Country?				
	1622 N. Wolf Street		21213		USA				
	11. Marital Status		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Name Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: Black
	1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		Viet Nam						
15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)			16b. Kind of Business/Industry				
Elementary/Secondary (0-12) 12th grade		College (1-4 or 5+) Transit Operator			MTA				
17. Father's Name (First, Middle, Last)		18. Mother's Name (First, Middle, Maiden Surname)							
Joseph Norris, Sr.		Ruby Ann Forbes							
19a. Informant's Name/Relationship (Type, Print)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)							
Joseph Norris, 3rd/Son		8616 Inwood Road Windsor Mill, Md 21244							
20a. Method of Disposition <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place)			4/20/2007			20c. Location - City or Town, State Owings Mills, Md.	
		Garrison Forest Vet. Cem.			5/20/2007			Woodlawn, Maryland	
21. Signature of Funeral Service Licensee		22. Name and Address of Facility			Chatman-Harris Funeral Home				
		5240 Reisterstown Rd Baltimore, Md 21215							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.		23b. Approximate Interval Between Onset and Death							
Immediate Cause (Final disease or condition resulting in death)		Due to (or as a consequence of):			2 MONTHS				
{ Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		a. SQUAMOUS CELL CARCINOMA OF LUNG							
		b. ASPIRATION PNEUMONIA			2 WEEKS				
		c. ESOPHAGEAL-BRONCHIAL FISTULA			2 WEEKS				
		d. RESPIRATORY FAILURE			1 WEEK				
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year				
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown				
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred			
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
29b. Signature and title of certifier 		29c. License number P 9150			29d. Date signed (Month, Day, Year) APRIL 12, 2007				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)									
YASMIN ALIHAMIRANI, MD, 600 N. WOLFE STREET, BALTIMORE, MD, 21205									
31. Date filed (Month, Day, Year) APR 17 2007		32. Registrar's Signature 							

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 23c show any injury or other traumatic event, the Medical Examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 12151

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Anne Carter Nelson					2. Date of Death Month Day Year April 13, 2007	3. Time of Death 6:10 p M		
	4a. Facility Name (If not institution, give street and number) Rose Manor Assisted Living			4b. City, Town, or Location of Death Ellicott City		4c. County of Death Howard			
Funeral Director	5. Social Security Number 251-07-6946		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 87 Yrs.	If Under 1 Year Months Days Hours Min. 	8. Date of Birth (Month, Day, Year) March 26, 1920	9. Birthplace (State or Foreign Country) S. Carolina		
	Usual Residence of Decedent Maryland		10a. State Maryland		10b. County Baltimore		10c. City, Town or Location Nottingham	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
To Be Completed by Funeral Director	10e. Street and Number 4014 Link Ave			10f. Zip Code 21236		10g. Citizen of What Country? USA			
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: 		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: 		14. Race - American Indian, Black, White, etc. White		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Clerical		16b. Kind of Business/Industry Balt. Co. Public Lib.			
	17. Father's Name (First, Middle, Last) James Wilburn Carter			18. Mother's Name (First, Middle, Maiden Surname) Florence Virginia Davis					
	19a. Informant's Name/Relationship (Type, Print) Patricia Lobos- daughter			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4014 Link Ave, Nottingham, MD 21236		20c. Location - City or Town, State Elkridge, MD			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) ► <i>M.W.C.</i>			20b. Place of Disposition (Name of cemetery, crematory or other place) Meadowridge Memorial Pk.		Date 4/17/2007			
	21. Signature of Funeral Service Licensee ► <i>M.W.C.</i>			22. Name and Address of Facility Gary L. Kaufman Funeral Home at MMP, INC. 7250 Washington Blvd., Elkridge, MD 21075					
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							Approximate Interval Between Onset and Death 1 YEAR	
	<p>a. Due to (or as a consequence of): CONGESTIVE HEART FAILURE</p> <p>b. Due to (or as a consequence of): </p> <p>c. Due to (or as a consequence of): </p> <p>d. Due to (or as a consequence of): </p>								
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown			23c. If yes, outcome pf pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown <input type="checkbox"/> Other (specify) _____		23d. Date of delivery Month Day Year			
Medical Certification: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
								24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide			28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred		
				28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 		28f. Location (Street and Number or Rural Route Number, City or Town, State) 			
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
	29b. Signature and title of certifier ► <i>E.W. Cole MD</i>			29c. License number D 16354		29d. Date signed (Month, Day, Year) 4/16/2007			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) E.W. COLE STAGNES 900 CATON AVE BALTIMORE MD 21229								
State Registrar	31. Date filed (Month, Day, Year) APR 17 2007		32. Registrar's Signature ► <i>Jeanne B. Parker</i>						

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division or Vital Records, P.O. Box 68760,

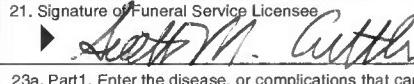
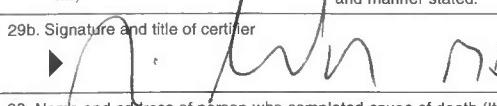
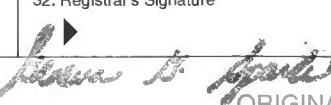
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1 - For State Amend #19b, per FH, g866, 4/17/07 TT Certificate of Death

Reg. No. 2007 12152

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) LILYAN NAVIASKY				2. Date of Death Month Day Year APRIL 12 2007	3. Time of Death M 8:30 A M		
	4a. Facility Name (If not institution, give street and number) SPRINGHOUSE		4b. City, Town, or Location of Death BALTIMORE		4c. County of Death BALTIMORE			
Funeral Director	5. Social Security Number 216-07-8218	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 94 Yrs.	If Under 1 Year Months Days Hours Min. <input type="checkbox"/>	If Under 24 Hrs. <input type="checkbox"/>	8. Date of Birth (Month, Day, Year) 06/28/1912	9. Birthplace (State or Foreign Country) MD	
To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State MD 10b. County BALTIMORE 10c. City, Town or Location BALTIMORE						10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
	10e. Street and Number 8911 REISTERTOWN ROAD			10f. Zip Code 21208		10g. Citizen of What Country? U.S.A		
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) HOMEMAKER		16b. Kind of Business/Industry OWN HOME			
	17. Father's Name (First, Middle, Last) SAMUEL RUDE			18. Mother's Name (First, Middle, Maiden Surname) SARAH HAHN				
	19a. Informant's Name/Relationship (Type, Print) NEIL NAVIASKY / SON		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 555 BEAVER CREEK DRIVE - LAKE GEORGE, CO. 80827					
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) BETH TFILOH CONG.		20b. Place of Disposition (Name of cemetery, crematory or other place)		Date 04/15/2007	20c. Location - City or Town, State WOODLAWN, MD		
	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208					
Physician /Medical Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Congestive heart failure						Approximate Interval Between Onset and Death	
Medical Certification: To Be Completed by Physician/Medical Examiner	23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown						23c. If yes, outcome pf pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown	23d. Date of delivery Month Day Year
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
							24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred		
			28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
	29b. Signature and title of certifier 		29c. License number 000000		29d. Date signed (Month, Day, Year) 04/12/07			
	30. Name and address of person who completed cause of death (Item 23a). (Type, Print) Alison Whisen, 9000 Old Conduit Rd, Baltimore, MD 21208							
State Registrar	31. Date filed (Month, Day, Year) APR 17 2007		32. Registrar's Signature  ORIGINAL					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 12153

1- For
State
Registrar

1. Decedent's Name (First, Middle, Last)

Janet Marie Olszewski

2. Date of Death
Month Day Year

April 11, 2007

3. Time of Death

10:03 AM

Physician
/Medical
Examiner

Permit Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To Be Completed by Funeral Director

4a. Facility Name (If not institution, give street and number)

538 South Wickham Road

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

218-42-8223

6. Sex

1 M

2 F

7. Age (In yrs. last birthday)

61

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

Jun. 26, 1945

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 Yes

2 No

10e. Street and Number

538 South Wickham Road

10f. Zip Code

21229

10g. Citizen of What Country?

United States

11. Marital Status

1 Never Married 2 Married
3 Widowed 4 Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 Yes 2 No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12) 12

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

Sales Associate

16b. Kind of Business/Industry

Flooring

17. Father's Name (First, Middle, Last)

John Cooper

18. Mother's Name (First, Middle, Maiden Surname)

Lucille Stillinger Eitze

19a. Informant's Name/Relationship (Type, Print)

Greg Olszewski - Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

987 Regina Drive, Halethorpe, MD 21227

20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Baltimore National Cemetery

Date

4-16-2007

20c. Location - City or Town, State

Catonsville, MD

21. Signature of Funeral Service Licensee

John Cooper

22. Name and Address of Facility

Ambrose Funeral Home, Inc.
1328 Sulphur Spring Rd., Arbutus, MD 21227

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Approximate Interval Between Onset and Death

YEARS

a. PERIPHERAL VASCULAR DISEASE

Due to (or as a consequence of):

b. HYPER TENSION

Due to (or as a consequence of):

c. DIABETES MELLITUS II

Due to (or as a consequence of):

YEARS

YEARS

d.

YEARS

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No
9 Unknown

23c. If yes, outcome pf pregnancy

1 Live birth 2 Fetal death 3 Ectopic pregnancy
4 Pregnant at time of death 5 Other (specify)
9 Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 Yes 2 No 3 Probably 4 Unknown

25. Was case referred to medical examiner?

1 Yes 2 No

26. Place of Death (Check only one)

Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)

27. Manner of Death

1 Natural 5 Pending investigation
2 Accident 6 Could not be determined
3 Suicide
4 Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 Yes 2 No

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier
(Check only one)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

► *Jerry Malik*

MEDICAL DOCTOR

29c. License number

D0063501

29d. Date signed (Month, Day, Year)

April 12, 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

RABINA MALIK, MD - 405 FREDERICK ROAD, CATONSVILLE MD 21228

31. Date filed (Month, Day, Year)

APR 17 2007

32. Registrar's Signature

► *Jerry Malik*

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2007 12154
Reg. No.1 - For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Robert Henry Owings							2. Date of Death Month Day Year April 9, 2007	3. Time of Death 7:18 P M	
	4a. Facility Name (If not institution, give street and number) Carroll Hospital Center				4b. City, Town, or Location of Death Westminster			4c. County of Death Carroll		
Funeral Director	5. Social Security Number 218-09-1505		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 95 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) Dec. 25, 1911	9. Birthplace (State or Foreign Country) MD		
	10a. State MD		10b. County Baltimore		10c. City, Town or Location Reisterstown			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
To Be Completed by Funeral Director	10e. Street and Number 2506 Hollingsworth Road				10f. Zip Code 21136		10g. Citizen of What Country? U.S.A.			
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: Elementary/Secondary (0-12) 12		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: Carpenter		14. Race - American Indian, Black, White, etc. Specify: White			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Carpenter		16b. Kind of Business/Industry Construction					
	17. Father's Name (First, Middle, Last) Charles H. Owings				18. Mother's Name (First, Middle, Maiden Surname) Mary Dorothea Rawlings					
	19a. Informant's Name/Relationship (Type, Print) Sonya L. Corum - Daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2506 Hollingsworth Road, Reisterstown, MD 21136					
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) Evergreen Memorial Pk. 4-13-07		20b. Place of Disposition (Name of cemetery, crematory or other place) Finksburg, MD		Date	20c. Location - City or Town, State 11824 Reisterstown Rd. Reisterstown, MD 21136				
	21. Signature of Funeral Service Licensee Stephen M. Jenkins				22. Name and Address of Facility ELINE FUNERAL HOME					
Physician /Medical Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death	
Medical Certification: To Be Completed by Physician/Medical Examiner	<p>a. Septic Shock Due to (or as a consequence of):</p> <p>b. Acute Renal failure Due to (or as a consequence of):</p> <p>c. C. diff toxin diarrhea Due to (or as a consequence of):</p> <p>d. Dementia</p>									
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year					
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. C. A. D. Chronic Atrial Fibrillation Deafness								23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)					
	29b. Signature and title of certifier DR. Raman B Kanewa MD		29c. License number D-0054218		29d. Date signed (Month, Day, Year) 04-09-07					
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. Raman B Kanewa, 349 Maleans drw, Westminster MD 21157		31. Date filed (Month, Day, Year) APR 17 2007		32. Registrar's Signature Vince A. Aponte					

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: This law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit once.

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, a Medical Examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2007 12155

1- For State Registrar

Physician /Medical Examiner		1. Decedent's Name (First, Middle, Last) Thomas Parrish				2. Date of Death Month April Day 13 Year 2007		3. Time of Death 7:20 PM							
Funeral Director		4a. Facility Name (If not institution, give street and number) Northwest Hospital				4b. City, Town, or Location of Death Randallstown		4c. County of Death Baltimore							
To Be Completed by Funeral Director		5. Social Security Number 214-88-3903	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 36 Yrs.	If Under 1 Year Months 0 Days 0 Hours 0 Min. 0	8. Date of Birth (Month, Day, Year) JAN 9, 1971		9. Birthplace (State or Foreign Country) MD							
To Be Completed by Funeral Director		10a. State MD		10b. County Baltimore		10c. City, Town or Location Gwynn Oak		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
To Be Completed by Funeral Director		10e. Street and Number 6419 Windsor Mill Rd				10f. Zip Code 21207		10g. Citizen of What Country? USA							
To Be Completed by Physician/Medical Examiner		11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: White		14. Race - American Indian, Black, White, etc. Specify: White								
To Be Completed by Physician/Medical Examiner		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Warehouse Foreman		16b. Kind of Business/Industry Food Distributor									
To Be Completed by Physician/Medical Examiner		17. Father's Name (First, Middle, Last) Thomas Wallace Parrish				18. Mother's Name (First, Middle, Maiden Surname) Gladys Speake									
To Be Completed by Physician/Medical Examiner		19a. Informant's Name/Relationship (Type, Print) Gladys Bonsall/Mother			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6419 Windsor Mill Rd Gwynn Oak, MD 21207										
To Be Completed by Physician/Medical Examiner		20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) Metro Crematory, Inc		20b. Place of Disposition (Name of cemetery, crematory or other place) Metro Crematory, Inc		Date 4/18/07	20c. Location - City or Town, State Baltimore, MD								
To Be Completed by Physician/Medical Examiner		21. Signature of Funeral Service Licensee C. Todd Dring		22. Name and Address of Facility MacNabb Funeral Home, P.A.		301 Frederick RD Catonsville, MD 21228									
To Be Completed by Physician/Medical Examiner		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) cirrhosis Approximate Interval Between Onset and Death													
To Be Completed by Physician/Medical Examiner		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last													
To Be Completed by Physician/Medical Examiner		a. Due to (or as a consequence of): cirrhosis													
To Be Completed by Physician/Medical Examiner		b. Due to (or as a consequence of):													
To Be Completed by Physician/Medical Examiner		c. Due to (or as a consequence of):													
To Be Completed by Physician/Medical Examiner		d. Due to (or as a consequence of):													
To Be Completed by Physician/Medical Examiner		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown <input type="checkbox"/> Other (Specify) _____		23d. Date of delivery Month Day Year									
To Be Completed by Physician/Medical Examiner		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. alcoholism													
To Be Completed by Physician/Medical Examiner		23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown													
To Be Completed by Physician/Medical Examiner		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No											
To Be Completed by Physician/Medical Examiner		25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)											
To Be Completed by Physician/Medical Examiner		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred							
To Be Completed by Physician/Medical Examiner		28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)									
To Be Completed by Physician/Medical Examiner		29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.													
To Be Completed by Physician/Medical Examiner		29b. Signature and title of certifier Trung Pham MD		29c. License number D47704		29d. Date signed (Month, Day, Year) 4/13/07									
State Registrar		31. Date filed (Month, Day, Year) APR 17 2007		32. Registrar's Signature Trung Pham											

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2007 12156

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Martin Felix Proctor							2. Date of Death Month Day Year April 11, 2007	3. Time of Death 5:35 A M
	4a. Facility Name (If not institution, give street and number) Prince George's Hospital			4b. City, Town, or Location of Death Cheverly			4c. County of Death Prince George's		
Funeral Director	5. Social Security Number 578 54 0772	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F XX	7. Age (In yrs. last birthday) 68 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) Aug 8, 1938	9. Birthplace (State or Foreign Country) Washington DC		
	10a. State Maryland		10b. County Prince George's		10c. City, Town or Location Seat Pleasant			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No XX	
To Be Completed by Funeral Director	10e. Street and Number 5623 Oakford Road			10f. Zip Code 20743			10g. Citizen of What Country? United States		
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced XX		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: 1959 1964		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: American Indian			14. Race - American Indian, Black, White, etc. Specify: American Indian	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+)		16b. Kind of Business/Industry Chief Stream Engineer				
	17. Father's Name (First, Middle, Last) Robert Lee Proctor			18. Mother's Name (First, Middle, Maiden Surname) Elizabeth E. Harley					
	19a. Informant's Name/Relationship (Type, Print) Teresa Proctor (Wife)			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5623 Oakford Road, Seat Pleasant, MD 20743					
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) XX			20b. Place of Disposition (Name of cemetery, crematory or other place) Maryland Veterans Cemetery			20c. Location - City or Town, State Cheltenham, Maryland		
	21. Signature of Funeral Service Cemetery MO1464			22. Name and Address of Facility Lee Funeral Home, Inc 6633 Old Alexandria Ferry Road, Clinton, MD 20735					
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Respiratory failure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Lung cancer								Approximate Interval Between Onset and Death
	a. Due to (or as a consequence of): Respiratory failure b. Due to (or as a consequence of): Lung cancer c. Due to (or as a consequence of): d.								
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year			
Medical Certification: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Coronary Artery disease COPD							23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown	
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA			Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred		
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State)		
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
	29b. Signature and title of certifier William Boyce			29c. License number D0043662			29d. Date signed (Month, Day, Year) 4/11/07		
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) William Boyce PC-Hosp 3001 Hospital Drive Cheverly MD 20785								
State Registrar	31. Date filed (Month, Day, Year) APR 17 2007		32. Registrar's Signature James B. Boyce		ORIGINAL				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 12157

1 - For State Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Zola Evelyn Pemberton							2. Date of Death Month April Day 11 Year 2007	3. Time of Death 2:17 AM
	4a. Facility Name (If not institution, give street and number) University of Maryland Medical Center				4b. City, Town, or Location of Death Baltimore			4c. County of Death	
Funeral Director	5. Social Security Number 217-20-1619	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 81 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) Feb. 6, 1926	9. Birthplace (State or Foreign Country) Maryland		
	Usual Residence of Decedent 10a. State Maryland				10b. County N/A			10c. City, Town or Location Baltimore	10d. Inside City Limits <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No
To Be Completed by Funeral Director	10e. Street and Number 2002 Girard Avenue				10f. Zip Code 21211			10g. Citizen of What Country? USA	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: White			14. Race - American Indian, Black, White, etc. White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Banking Clerk			16b. Kind of Business/Industry Maryland National Bank	
	17. Father's Name (First, Middle, Last) Charles A. Bowersox				18. Mother's Name (First, Middle, Maiden Surname) Zola Mae Harrison				
	19a. Informant's Name/Relationship (Type, Print) Robert L. Pemberton, Jr. Son				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 604 Burgess Street, Berlin, NH 03570				
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Lorraine Park Cemetery			Date 4/14/07	20c. Location - City or Town, State Woodlawn, Maryland
	21. Signature of Funeral Service Licensee Dawn B. Henss				22. Name and Address of Facility Burgee-Henss-Seitz Funeral Home, Inc. 21211 3631 Falls Road, Baltimore, Maryland				
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Stroke				Approximate Interval Between Onset and Death				
	a. Due to (or as a consequence of): Stroke								
	b. Due to (or as a consequence of):								
	c. Due to (or as a consequence of):								
	d. Due to (or as a consequence of):								
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown				23c. If yes, outcome pf pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify)			23d. Date of delivery Month Day Year	
Medical Certification: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. end-stage renal disease right-sided lung mass				23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown				
					24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year) 28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		
	28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier K. Pgs, MD Resident Physician				
					29c. License number P19807			29d. Date signed (Month, Day, Year) April 11, 2007	
State Registrar	31. Date filed (Month, Day, Year) APR 17 2007				32. Registrar's Signature [Signature]				

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural"; or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division or Vital Records, P.O. Box 68760,  To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 12158

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Katherine Peters					2. Date of Death Month April Day 7 Year 2007	3. Time of Death 3:10 PM	
	4a. Facility Name (If not institution, give street and number) Howard County General Hospital		4b. City, Town, or Location of Death Columbia			4c. County of Death Howard		
Funeral Director	5. Social Security Number 215-09-4053	6. Sex 1 M 2 F	7. Age (In yrs. last birthday) 89 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) 12/20/1917	9. Birthplace (State or Foreign Country) Maryland	
	Usual Residence of Decedent 10a. State MD 10b. County Howard 10c. City, Town or Location Jessup					10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
10e. Street and Number 8012 Blobs Park Road			10f. Zip Code 20794			10g. Citizen of What Country? United States		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: 8		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: White			14. Race - American Indian, Black, White, etc. Specify:	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+)			16b. Kind of Business/Industry Restaurant Owner Food		
17. Father's Name (First, Middle, Last) John Blob				18. Mother's Name (First, Middle, Maiden Surname) Crescentia Philipp				
19a. Informant's Name/Relationship (Type, Print) Anna Henline (Daughter)			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7948 Blobs Park Road Jessup, MD 20794					
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) Elizabeth Evans			20b. Place of Disposition (Name of cemetery, crematory or other place) Meadowridge Memorial Park		Date 4/11/07	20c. Location - City or Town, State Elkridge, Maryland		
21. Signatory of Funeral Service Licensee Elizabeth Evans			22. Name and Address of Facility Gary L. Kaufman Funeral Home at MMP, Inc. 7250 Washington Blvd Elkridge, MD 21075					
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Cardiomyopathy							Approximate Interval Between Onset and Death
	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last a. Renal Failure b. Respiratory Failure c. Due to (or as a consequence of): d. Due to (or as a consequence of):							
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome pf pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year) APR 17 2007		28b. Time of Injury M	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred Place of injury - At home, farm, street, factory, office building, etc. (Specify)		
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		28e. Location (Street and Number or Rural Route Number, City or Town, State) Shawn Evans, 5755 Cedar Lane Columbia, Maryland 21044						
29b. Signature and title of certifier Shawn Evans M.D.		29c. License number D0063653			29d. Date signed (Month, Day, Year) April 7, 2007			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Shawn Evans, 5755 Cedar Lane Columbia, Maryland 21044		31. Date filed (Month, Day, Year) APR 17 2007		32. Registrar's Signature Shawn B. Evans		ORIGINAL		

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 12159

1- For State Registrar

Physician /Medical Examiner

Funeral Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
 Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Division of Vital Records, P.O. Box 68760, US

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year		3. Time of Death
CHARLES Edward Phares		APRIL 11 2007		1543 M
4a. Facility Name (If not institution, give street and number) Baltimore VA Medical Center		4b. City, Town, or Location of Death Baltimore		4c. County of Death N/A
5. Social Security Number 219-26-7104		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) 68 Yrs.	8. Date of Birth (Month, Day, Year) 04/20/1938
9. Birthplace (State or Foreign Country) NJ		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
10a. State MD		10b. County Anne Arundel	10c. City, Town or Location Linthicum	
10e. Street and Number 716 Camp Meade Road		10f. Zip Code 21090		10g. Citizen of What Country? U.S.A.
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: white
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Food Service		16b. Kind of Business/Industry Food
17. Father's Name (First, Middle, Last) Charles Kinsler Phares			18. Mother's Name (First, Middle, Maiden Surname) Elizabeth Margaret Oswald	
19a. Informant's Name/Relationship (Type, Print) Mr. Steven Phares / son			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State) 23430 Chandler Ct; Hollywood, MD 20636	
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) <i>Jalt John m0120</i>		20b. Place of Disposition (Name of cemetery, crematory or other place) Chesapeake Cremation		Date 04/13/2007
20c. Location - City or Town, State Stevensville, MD		22. Name and Address of Facility Singleton Funeral Home, PA 1 Second Ave SW; Glen Burnie, MD 21061		
23. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.				
<p>Immediate Cause (Final disease or condition resulting in death) CONGESTIVE HEART FAILURE</p> <p>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</p> <p>a. Due to (or as a consequence of): CONGESTIVE HEART FAILURE</p> <p>b. Due to (or as a consequence of): ISCHEMIC CARDIOMYOPATHY</p> <p>c. Due to (or as a consequence of):</p> <p>d.</p> <p>Approximate Interval Between Onset and Death 7 years</p>				
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CHRONIC OBSTRUCTIVE PULMONARY DISEASE				
23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown				
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year) 28b. Time of Injury M	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
		28d. Describe how injury occurred		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) At home		28f. Location (Street and Number or Rural Route Number, City or Town, State) 10 North Greene Street Baltimore MD 21201		
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29c. License number AU4176435777539		29d. Date signed (Month, Day, Year) 4/11/07
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) STEPHEN THOMPSON, MD		32. Registrar's Signature Leanne B. Gandy		
31. Date filed (Month, Day, Year) APR 17 2007				

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2007 12160

1 - For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last)				2. Date of Death Month Day Year	3. Time of Death		
	Rose Josephine Pisz				April 16 2007	12: 15A M		
Funeral Director	4a. Facility Name (If not institution, give street and number) Riverview Care Center			4b. City, Town, or Location of Death Essex		4c. County of Death Baltimore		
	5. Social Security Number 212-03-2324	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 96 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days Hours Min.	8. Date of Birth (Month, Day, Year) Nov. 29 1910	9. Birthplace (State or Foreign Country) Maryland	
To Be Completed by Funeral Director	Usual Residence of Decedent							
	10a. State Maryland	10b. County Baltimore	10c. City, Town or Location Essex			10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
	10e. Street and Number 1 Eastern Blvd.			10f. Zip Code 21221		10g. Citizen of What Country? U.S.A.		
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No Specify: X		14. Race - American Indian, Black, White, etc. Specify: White		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 NA		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Inspector			16b. Kind of Business/Industry American Can Company		
	17. Father's Name (First, Middle, Last) UNKNOWN			18. Mother's Name (First, Middle, Maiden Surname) UNKNOWN				
	19a. Informant's Name/Relationship (Type, Print) George Watson (Friend)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 312 German Hill Road Baltimore, Maryland 21222					
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Holy Rosary Cemetery		Date April, 18	20c. Location - City or Town, State Dundalk, Maryland		
	21. Signature of Funeral Service Licensee ► Mark A. Chojnacki		22. Name and Address of Facility W. Dabrowski/Chojnacki Funeral Homes P.A. 1005 Dundalk Ave. Baltimore, Maryland 21224					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.						Approximate Interval Between Onset and Death years	
	Immediate Cause (Final disease or condition resulting in death)		Due to (or as a consequence of): coronary artery disease					
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		b. Due to (or as a consequence of):					
			c. Due to (or as a consequence of):					
			d. Due to (or as a consequence of):					
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify)				23d. Date of delivery Month Day Year	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Dementia						23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred		
			28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)		
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
	29b. Signature and title of certifier ► John Loh		29c. License number H 35593			29d. Date signed (Month, Day, Year) April 16, 2007		
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) John Loh 1124 Mage Ave., Baltimore, MD. 21221							
	31. Date filed (Month, Day, Year) APR 17 2007		32. Registrar's Signature John Loh					

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 12161

1 - For State Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Christopher W. Patterson					2. Date of Death Month Day Year April 10 2007	3. Time of Death 8:52 PM		
	4a. Facility Name (If not institution, give street and number) Northwest Hospital		4b. City, Town, or Location of Death Randallstown			4c. County of Death Baltimore			
Funeral Director	5. Social Security Number 130-46-2250	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 52 Yrs.	If Under 1 Year Months Days Hours Min.	8. Date of Birth (Month, Day, Year) April 20, 1954	9. Birthplace (State or Foreign Country) New York			
	Usual Residence of Decedent 10a. State Maryland		10b. County Baltimore	10c. City, Town or Location Pikesville			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
To Be Completed by Funeral Director	10e. Street and Number 7409 Sudbrook Rd.			10f. Zip Code 21208		10g. Citizen of What Country? U.S.A.			
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: 1968	13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: Black			14. Race - American Indian, Black, White, etc. Specify: Black			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Chemist			16b. Kind of Business/Industry Chemical Research			
	17. Father's Name (First, Middle, Last) Wallace patterson			18. Mother's Name (First, Middle, Maiden Surname) Minnie McCoy					
	19a. Informant's Name/Relationship (Type, Print) Mrs. Lenora D. Patterson		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7409 Sudbrook Rd. Pikesville, Maryland 21208						
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) Melody Nola Built MC 1293		20b. Place of Disposition (Name of cemetery, crematory or other place) Dulaney Valley Memorial Gardens		Date 04/16/07	20c. Location - City or Town, State Timonium, Maryland			
	21. Signature of Funeral Service Licensee Melody Nola Built MC 1293		22. Name and Address of Facility Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043						
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							Approximate Interval Between Onset and Death	
	<p>a. <u>Atherosclerotic Cardiovascular Disease</u> Due to (or as a consequence of):</p> <p>b. <u>Hypertension</u> Due to (or as a consequence of):</p> <p>c. <u>End Stage Kidney Disease.</u> Due to (or as a consequence of):</p> <p>d. _____</p>								
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown <input type="checkbox"/> Other (specify) _____					23d. Date of delivery Month Day Year	
Medical Certification: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) _____			23f. Location (Street and Number or Rural Route Number, City or Town, State)			
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred			
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)						
	29b. Signature and title of certifier Jennifer George DO		29c. License number 10055644			29d. Date signed (Month, Day, Year) April 10, 2007			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Northwest Hospital 5401 Old Court Road Randallstown MD 21133								
	31. Date filed (Month, Day, Year) APR 17 2007		32. Registrar's Signature Jane D. Jones						

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2007 12162

1- For
State
Registrar

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Warren Rudolph Palmer

2. Date of Death

Month Day Year

3. Time of Death

April 11, 2007

6:10 a. M

Funeral
Director

Usual Residence of Decedent:

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Cockeysville

10d. Inside City Limits

1 Yes 2 No

10e. Street and Number

10535 York Road

10f. Zip Code

21030

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 Never Married 2 Married
3 Widowed 4 Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 Yes 2 No
If Yes, Give
Year or Dates:

1944
1946

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 Yes 2 No Specify:

14. Race - American Indian,

Black, White, etc.

Specify:

White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

unkn

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Machinist

16b. Kind of Business/Industry

Cork & Seal Company

17. Father's Name (First, Middle, Last)

Chaney Jefferson Palmer

18. Mother's Name (First, Middle, Maiden Surname)

Florence Elizabeth Palmer

19a. Informant's Name/Relationship (Type, Print)

Ms. Peggy Long

Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

11002 Gateview Road Cockeysville, Maryland 21030

20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

St. John's Cemetery

Date

04/14/07

20c. Location - City or Town, State

Ellicott City, MD

21. Signature of Funeral Service Licensee



22. Name and Address of Facility

Slack Funeral Home, P.A.

3871 Old Columbia Pike Ellicott City, MD 21043

Approximate
Interval Between
Onset and Death

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. DEMENTIA

Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No

9 Unknown

23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 3 Ectopic pregnancy
4 Pregnant at time of death 5 Other (specify) _____

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 Yes 2 No 3 Probably 4 Unknown

25. Was case referred to medical examiner?

1 Yes 2 No

26. Place of Death (Check only one)

Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) HOSPICE

27. Manner of Death

1 Natural 5 Pending investigation
2 Accident 6 Could not be determined
3 Suicide 4 Homicide

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 Yes 2 No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

(Check only one)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier



29c. License number

D43725

29d. Date signed (Month, Day, Year)

April 11, 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR. TARIQ MAHMOOD 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093

31. Date filed (Month, Day, Year)

APR 17 2007

32. Registrar's Signature



APRIL 11, 2007 6:10 a.m.

Baltimore, Maryland 21215-0036

WARREN PALMER
Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2007 12163

1. For State
Registrar**Physician/
Medical Examiner**

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death 1227 hrs
--	------------------------------------	------------------------------

Chloe Michelle Perez

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

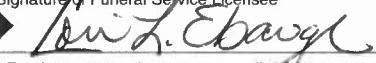
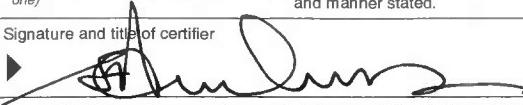
Certificate of Death

Reg. No.

2007 12164

1- For
State
Registrar

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last) William T. Rockwell, Sr.		2. Date of Death Month April Day 12 Year 2007	3. Time of Death 9:35 P M	
4a. Facility Name (If not institution, give street and number) 1818 Cedar Drive		4b. City, Town, or Location of Death Severn		
4c. County of Death Anne Arundel				
5. Social Security Number 220-28-9758		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 73 Yrs.	
		If Under 1 Year Months	If Under 24 Hrs. Days Hours Min.	
		8. Date of Birth (Month, Day, Year) Apr. 28, 1933		9. Birthplace (State or Foreign Country) West Virginia
Usual Residence of Decedent				
10a. State Maryland	10b. County Anne Arundel	10c. City, Town or Location Severn		
		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
10e. Street and Number 1818 Cedar Drive		10f. Zip Code 21144	10g. Citizen of What Country? United States	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: '50-'53	13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	14. Race - American Indian, Black, White, etc. Specify: White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Model Maker	16b. Kind of Business/Industry Defense Industry	
17. Father's Name (First, Middle, Last) Charles E. Rockwell		18. Mother's Name (First, Middle, Maiden Surname) Myrtle Twigg		
19a. Informant's Name/Relationship (Type, Print) William T. Rockwell, Jr./ Son		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1818 Cedar Dr., Severn, Maryland 21144		
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Crownsville MD Vet. Cem. 2007	20c. Date of Disposition April 16, 2007	
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Kirkley-Ruddick Funeral Home, P.A. 421 Crain Hwy., S.E., Glen Burnie, MD 21061		
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		Approximate Interval Between Onset and Death		
a. Metastatic Disease of Brain Due to (or as a consequence of): Lung Carcinoma .				
b. Due to (or as a consequence of):				
c. Due to (or as a consequence of):				
d. _____				
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown <input type="checkbox"/> Other (specify) _____		
23d. Date of delivery Month Day Year				
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Ischemic Cardiomyopathy Congestive Heart Failure.				
23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		23f. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	
		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred	
		28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		
		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier 		
		29c. License number D51596	29d. Date signed (Month, Day, Year) April 13, 2007	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) K. Ambalavanar, M.D., 7845 Oakwood Rd., Suite 107, Glen Burnie, MD 21061		31. Date filed (Month, Day, Year) APR 17 2007		
		32. Registrar's Signature 		

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State
Registrar

DHMH 17 Rev 1/2001

ORIGINAL

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2007 12165

1- For
State
Registrar

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Edeline Rhodes Jr.

2. Date of Death

Month Day Year

3. Time of Death

1153 P M

4a. Facility Name (If not institution, give street and number)

Maryland General Hospital

4b. City, Town, or Location of Death

Baltimore City

4c. County of Death

Funeral
Director

5. Social Security Number

578-50-8492

6. Sex

M

F

7. Age (In yrs. last birthday)

67

Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Days

Hours

Min.

8. Date of Birth

(Month, Day, Year)

Dec. 24, 1939

9. Birthplace (State or Foreign Country)

Washington DC

To Be Completed by Funeral Director

Usual Residence of Decedent

Department of Health and Mental Hygiene
Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

Oxon Hill

10d. Inside City Limits

Yes No

10e. Street and Number

6805 Livingston Road

10f. Zip Code

20745

10g. Citizen of What Country?

U.S.A.

11. Marital Status

Never Married Married
 Widowed Divorced

12. Was Decedent Ever in U.S. Armed Forces?

Yes No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

Yes No
Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12) 12th

College (1-4 or 5+) 12th

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Plumber

16b. Kind of Business/Industry

Local Union 5

17. Father's Name (First, Middle, Last)

Edeline B. Rhodes, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Lillian M. Dorsey

19a. Informant's Name/Relationship (Type, Print)

Donna Treyes (Daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

26855 Cat Creek Road Mechanicsville, MD 20659

20a. Method of Disposition

Burial Cremation Removal from State
 Donation Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metropolitan Crematory

Date

April 11, 2007

20c. Location - City or Town, State

Alexandria Virginia

21. Signature of Funeral Service Licensee

Krenta D. Silby muz84

22. Name and Address of Facility

Lee Funeral Home, INC.

6633 Old Alexandria Ferry Road Clinton, MD 20735

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Approximate Interval Between Onset and Death

4-5 weeks

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

a. MOTOR VEHICLE ACCIDENT

Due to (or as a consequence of):

Traumatic Brain Injury

Due to (or as a consequence of):

Septic Shock

Due to (or as a consequence of):

APPROVAL APPROVED BY MEDICAL EXAMINER

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?
 Yes No
 Unknown

23c. If yes, outcome pf pregnancy
 Live birth Fetal death Ectopic pregnancy
 Pregnant at time of death Unknown Other (Specify)

23d. Date of delivery
Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

Yes No Probably Unknown

25. Was case referred to medical examiner?

Yes No

26. Place of Death (Check only one)

Hospital: Inpatient ER/Outpatient DOA

Other: Nursing Home Residence Other (Specify)

27. Manner of Death

Natural Pending investigation
 Accident Could not be determined
 Suicide Determined
 Homicide

28a. Date of Injury (Month, Day, Year)

March 7, 2007

0851 AM

28b. Time of Injury

0851 AM

28c. Injury at Work?

Yes No

28d. Describe how injury occurred

Motor Vehicle Crash

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Street

29a. Certifier

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

24a. Was an autopsy performed?

Yes No

24b. Were autopsy findings available prior to completion of cause of death?

Yes No

29b. Signature and title of certifier

M.D.

29c. License number

D47405

29d. Date signed (Month, Day, Year)

4/13/07

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

LIAQAT ALI MD 827 Linden Ave MGH Baltimore MD 21201

31. Date filed (Month, Day, Year)

APR 17 2007

32. Registrar's Signature

ORIGINAL

6

20

Division or Vital Records, P.O. Box 68760, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

certificate.

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 12166

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) John Robb							2. Date of Death Month April Day 8 Year 2007	3. Time of Death 12:53 a.m.		
	4a. Facility Name (If not institution, give street and number) 101 Oden Hall Ave #517			4b. City, Town, or Location of Death Gaithersburg			4c. County of Death Montgomery				
Funeral Director	5. Social Security Number 577-22-8246	6. Sex M	7. Age (In yrs. last birthday) 80 Yrs.	If Under 1 Year Months	If Under 24 Mo. Days	8. Date of Birth (Month, Day, Year) Nov 4, 1926	9. Birthplace (State or Foreign Country) Illinois				
	Usual Residence of Decedent 10a. State MD 10b. County Montgomery 10c. City, Town or Location Gaithersburg			10d. Inside City Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>							
To Be Completed by Funeral Director	10e. Street and Number 101 Oden Hall Avenue #517				10f. Zip Code 20877		10g. Citizen of What Country? USA				
	11. Marital Status Never Married		12. Was Decedent Ever in U.S. Armed Forces? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Specify Yes or No) Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Specify:			14. Race - American Indian, Black, White, etc. white				
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 5+	unk			16b. Kind of Business/Industry computers				
	17. Father's Name (First, Middle, Last) Carroll Robb				18. Mother's Name (First, Middle, Maiden Surname) Olive Harris						
	19a. Informant's Name/Relationship (Type, Print) Margaherita/niece				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13690 Ballantrae Lane Waldorf, MD 20601						
	20a. Method of Disposition Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input checked="" type="checkbox"/> Other (Specify) in state		20b. Place of Disposition (Name of cemetery, crematory or other place)		Date	20c. Location - City or Town, State					
	21. Signature of Funeral Service Licensee Donald S. Wade, Director		22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201								
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death D me		
	<p>a. Acute myocardial infarction Due to (or as a consequence of):</p> <p>b. Atherosclerotic heart disease Due to (or as a consequence of):</p> <p>c. _____ Due to (or as a consequence of):</p> <p>d. _____</p>										
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Unknown <input type="checkbox"/>			23d. Date of delivery Month Day Year					
Medical Certification: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Hypothyroid								23e. Did tobacco use contribute to the cause of death? Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		
									24a. Was an autopsy performed? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	24b. Were autopsy findings available prior to completion of cause of death? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
	25. Was case referred to medical examiner? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>								26. Place of Death (Check only one) Hospital: Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA <input type="checkbox"/> Other: Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify)		
	27. Manner of Death Natural <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/>		28a. Date of Injury (Month, Day Year) 5/12/2007		28b. Time of Injury M		28c. Injury at Work? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		28d. Describe how injury occurred		
	5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) At home						28f. Location (Street and Number or Rural Route Number, City or Town, State) 2101 Medical Park Dr Silver Spring MD 20902		
	29a. Certifier (Check only one) Medical Examiner : On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								29c. License number DOO428		
	29b. Signature and title of certifier John Brecher MD OME								29d. Date signed (Month, Day, Year) April 12, 2007		
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) John BRECHER MD OME										
State Registrar	31. Date filed (Month, Day, Year) APR 17 2007		32. Registrar's Signature John Brecher								

Baltimore, Maryland 21215-0036

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#19a per FH G866, 4/17/07 WS

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 12167

1- For
State
Registrar

Physician
/Medical
Examiner

Funeral Director	1. Decedent's Name (First, Middle, Last) MALIYAH D. REGIS				2. Date of Death Month 4 Day 13 Year 2007	3. Time of Death 0853 M	
	4a. Facility Name (If not institution, give street and number) UNIVERSITY MARYLAND HOSP.		4b. City, Town, or Location of Death BALTIMORE		4c. County of Death N/A		
5. Social Security Number 218 63 3877		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 4 Yrs.	If Under 1 Year Months 0 Days 0	If Under 24 Hrs. Hours 0 Min. 0	8. Date of Birth (Month, Day, Year) MAY 8, 2002	9. Birthplace (State or Foreign Country) MD.
10a. State MD.		10b. County N/A		10c. City, Town or Location BALTIMORE			10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No
10e. Street and Number 2582 CECIL AVENUE				10f. Zip Code 21218		10g. Citizen of What Country? USA	
11. Marital Status X <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: BLACK	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) PRE-K		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) NONE		16b. Kind of Business/Industry NONE			
17. Father's Name (First, Middle, Last) ANTONIO REGIS				18. Mother's Name (First, Middle, Maiden Surname) KIANAH BRYANT			
19a. Informant's Name/Relationship (Type, Print) KIANAH BRYANT (Mother)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2582 CECIL AVE. BALTO, MD. 21218			
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) GARDENS OF FAITH		Date APR. 19, 2007	20c. Location - City or Town, State BALTIMORE, MD.		
21. Signature of Funeral Service Licensee Bernadene J. Scruggs		22. Name and Address of Facility CALVIN B. SCRUGGS FUNERAL HOME 1412 E. PRESTON ST. BALTO, MD. 21213					
23a. Part I. Enter the disease, or complications, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death)		Approximate Interval Between Onset and Death					
a. Due to (or as a consequence of): PNEUMONIA							
b. Due to (or as a consequence of): PANHYPOTHYROIDISM							
c. Due to (or as a consequence of): ENCEPHALOMALACIA							
d.							
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 4 <input type="checkbox"/> Pregnant at time of death 9 <input type="checkbox"/> Unknown		23d. Date of delivery Month Year			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown							
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No					
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year) M		28b. Time of Injury M 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29c. License number H0062021					
29b. Signature and title of certifier Donald Van Wie Jr.		29d. Date signed (Month, Day, Year) 4/13/07					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DONALD VAN WIE JR. 22 S. GREENE STREET Baltimore, MD 21201							
31. Date filed (Month, Day, Year) APRIL 1 2007		32. Registrar's Signature [Signature]					

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760, *ES*

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2007 12168

1- For
State
Register

1. Decedent's Name (First, Middle, Last)

Evelyn Joy Redifer

2. Date of Death

Month Day Year

April 13, 2007

3. Time of Death

4:55 P M

Physician /Medical Examiner

4a. Facility Name (If not institution, give street and number)

Dove House Hospice

4b. City, Town, or Location of Death

Westminster

4c. County of Death

Carroll

Funeral Director

5. Social Security Number

215-34-5424

6. Sex

1 M

2 F

7. Age (In yrs. last birthday)

68

Yrs.

If Under 1 Year

Months Days Hours Min.

8. Date of Birth

(Month, Day, Year)

July 31, 1938

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural"; or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

10a. State

MD

10b. County

Baltimore

10c. City, Town or Location

Glyndon

10d. Inside City Limits

1 Yes 2 No

10e. Street and Number

3536 Butler Road

10f. Zip Code

21071

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 Never Married 2 Married
3 Widowed 4 Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 Yes 2 No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12) 11

College (1-4 or 5+) 11

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Secretary

16b. Kind of Business/Industry

Office Administration

17. Father's Name (First, Middle, Last)

Clifford Frebertshauser

18. Mother's Name (First, Middle, Maiden Surname)

Elizabeth Schaeffer

19a. Informant's Name/Relationship (Type, Print)

Robert Redifer - Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3536 Butler Road, Glyndon, MD 21071

20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Carroll Cremation

Date

4-16-07

20c. Location - City or Town, State

Hampstead, MD

21. Signature of Funeral Service Licensee

► Zewilliams

22. Name and Address of Facility

11824 Reisterstown Road
ELINE FUNERAL HOME Reisterstown, MD 21136

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Aspiration pneumonia
Due to (as a consequence of):

Approximate Interval Between Onset and Death

1 month

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Stroke
Due to (as a consequence of):

7 days

c. Due to (as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 9 Unknown

23c. If yes, outcome pf pregnancy

1 Live birth 2 Fetal death 3 Ectopic pregnancy

4 Pregnant at time of death 5 Other (specify)

9 Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Parkinson's Disease

23e. Did tobacco use contribute to the cause of death?

1 Yes 2 No 3 Probably 4 Unknown

25. Was case referred to medical examiner?

1 Yes 2 No

Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other:

4 Nursing Home 5 Residence 6 Other (Specify) Hospice

27. Manner of Death

1 Natural 5 Pending investigation
2 Accident 6 Could not be determined
3 Suicide 4 Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 Yes 2 No

28d. Describe how injury occurred

29a. Certifier (Check only one)

2 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

► Babak Imanol

29c. License number

H53939

29d. Date signed (Month, Day, Year)

4/16/2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Babak Imanol, DO; 218 Washington Heights Med Ctr; Westminster, MD 21157

31. Date filed (Month, Day, Year)

APR 17 2007

32. Registrar's Signature

James B. Jones

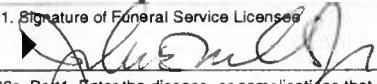
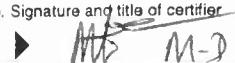
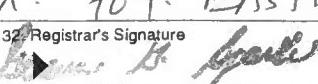
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 12169

1 - For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Angela Rose Stella						2. Date of Death Month Day Year April 15, 2007	3. Time of Death 9:20 PM		
	4a. Facility Name (If not institution, give street and number) Riverview Nursing Home			4b. City, Town, or Location of Death Essex			4c. County of Death Baltimore			
Funeral Director	5. Social Security Number 218-10-8128		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 92 Yrs.	If Under 1 Year Months Days Hours Min.	8. Date of Birth (Month, Day, Year) October 12, 1914		9. Birthplace (State or Foreign Country) Maryland		
	10a. State Maryland		10b. County Baltimore	10c. City, Town or Location Edgemere			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
10e. Street and Number 2316 Lodge Forrest Drive				10f. Zip Code 21219			10g. Citizen of What Country? USA			
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: 2000			13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: White			14. Race - American Indian, Black, White, etc. White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 9 years				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Housewife			16b. Kind of Business/Industry Own Home			
17. Father's Name (First, Middle, Last) Dominic Patucci					18. Mother's Name (First, Middle, Maiden Surname) Mary Aquino					
19a. Informant's Name/Relationship (Type, Print) Sharon Lingenfelder niece					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2316 Lodge Forrest Drive, Edgemere, MD. 21219					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) Holy Redeemer Cemetery				20b. Place of Disposition (Name of cemetery, crematory or other place) Holy Redeemer Cemetery			Date April 19, 2007	20c. Location - City or Town, State Baltimore, Maryland		
21. Signature of Funeral Service Licensee 					22. Name and Address of Facility Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, Md. 21222					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Advanced Demencia									Approximate Interval Between Onset and Death Un-known	
23b. Decedent's Final disease or condition resulting in death Advanced Demencia										
23c. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Htn, Osteoporosis, COPD, Malnutrition										
23d. Date of delivery Month Day Year										
23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown										
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No									24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No									26. Place of Death (Check only one) <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA <input type="checkbox"/> Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)	
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide									28a. Date of Injury (Month, Day, Year) 28b. Time of Injury M 28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No 28d. Describe how injury occurred	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)									28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
29b. Signature and title of certifier 									29c. License number D-38754	29d. Date signed (Month, Day, Year) 04-16-2007
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MALIKA WASSEM 709. EASTERN BLVD - MD - 21221										
31. Date filed (Month, Day, Year) APR 17 2007				32. Registrar's Signature 						

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

State
Registrar

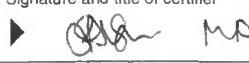
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 12170

1 - For State Registrar

Physician /Medical Examiner		1. Decedent's Name (First, Middle, Last) William Scott Sexton					2. Date of Death Month Day Year 04 10 2007		3. Time of Death 09:22 AM	
Funeral Director		4a. Facility Name (If not institution, give street and number) PENINSULA REGIONAL MEDICAL CENTER					4b. City, Town, or Location of Death Salisbury		4c. County of Death Nicomico	
To Be Completed by Funeral Director		5. Social Security Number 219-86-7762	6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) 44 Yrs.	If Under 1 Year Months 	If Under 24 Hrs. Days 	8. Date of Birth (Month, Day, Year) April 1, 1963	9. Birthplace (State or Foreign Country) Maryland		
To Be Completed by Funeral Director		10a. State Maryland					10b. County Harford		10c. City, Town or Location Aberdeen	
To Be Completed by Funeral Director		10e. Street and Number 425 Wye Drive					10f. Zip Code 21001		10g. Citizen of What Country? U.S.A.	
To Be Completed by Physician/Medical Examiner		11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		
To Be Completed by Physician/Medical Examiner		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Apartment Maintenance		16b. Kind of Business/Industry Apt./Condo Complex				
To Be Completed by Physician/Medical Examiner		17. Father's Name (First, Middle, Last) Kyle R. Sexton					18. Mother's Name (First, Middle, Maiden Surname) Rose Spicer			
To Be Completed by Physician/Medical Examiner		19a. Informant's Name/Relationship (Type. Print) Joseph Lovrich (Brother-in-law)			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 316 Huntsman Ct Bel Air, MD 21015					
To Be Completed by Physician/Medical Examiner		20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Dublin Missionary Cem.		Date 04-13-2007	20c. Location - City or Town, State Darlington, Maryland			
To Be Completed by Physician/Medical Examiner		21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Schimunek Funeral Home of Bel Air Inc. 610 W. Macphail Rd Bel Air, MD 21014						
To Be Completed by Physician/Medical Examiner		23. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) END STAGE LIVER DISEASE					Approximate Interval Between Onset and Death			
To Be Completed by Physician/Medical Examiner		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last ACUTE RENAL FAILURE SEPSIS ARDS								
To Be Completed by Physician/Medical Examiner		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome pf pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify)		23d. Date of delivery Month Day Year				
To Be Completed by Physician/Medical Examiner		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Hepatitis C, Alcohol Abuse					23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
To Be Completed by Physician/Medical Examiner		25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No				
To Be Completed by Physician/Medical Examiner		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year) 	28b. Time of Injury M	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)			
To Be Completed by Physician/Medical Examiner		29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
To Be Completed by Physician/Medical Examiner		29b. Signature and title of certifier 		29c. License number 063433		29d. Date signed (Month, Day, Year) 4/10/17				
To Be Completed by Physician/Medical Examiner		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NEIL DORRIS 106 MILFORD ST, #5D4B, SALISBURY, MD 21804								
To Be Completed by Physician/Medical Examiner		31. Date filed (Month, Day, Year) APR 17 2007		32. Registrar's Signature 						

Baltimore, William 900-30-9496, Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene
Certificate of Death

2007 12171
Reg. No.

1 - For State Registrar		1. Decedent's Name (First, Middle, Last) NISAN SHNEYDER								2. Date of Death Month April Day 15 Year 2007		3. Time of Death 3:34 A M	
Physician /Medical Examiner		4a. Facility Name (If not institution, give street and number) NORTH WEST HOSPITAL				4b. City, Town, or Location of Death RANDALLSTOWN				4c. County of Death BALTIMORE			
Funeral Director		5. Social Security Number 104-80-6938		6. Sex 1 M 2 F	7. Age (In yrs. last birthday) 61 Yrs.	If Under 1 Year Months		If Under 24 Hrs. Hours		8. Date of Birth (Month, Day, Year) 6-18-1945		9. Birthplace (State or Foreign Country) Russia	
To Be Completed by Funeral Director		Usual Residence of Decedent 10a. State MD 10b. County Baltimore 10c. City, Town or Location Reisterstown								10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
		10e. Street and Number 12001 Tarragon Rd., Apt. J.				10f. Zip Code 21136				10g. Citizen of What Country? U.S.A.			
Physician /Medical Examiner		11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No Specify:			14. Race - American Indian, Black, White, etc. white Specify:			
		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 4			16b. Kind of Business/Industry maintenance engineer			16c. Kind of Business/Industry real estate development			
		17. Father's Name (First, Middle, Last) Yekob Shneyder				18. Mother's Name (First, Middle, Maiden Surname) Frida Milkhiker							
		19a. Informant's Name/Relationship (Type, Print) Olga Shneyder, wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12001 Tarragon Rd., Apt J, Reisterstown, Md. 21136							
		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Riverside Cemetery			Date April 17, 2007		20c. Location - City or Town, State Rochelle Park, New Jersey			
		21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Loring Byers Funeral Directors, Inc., 8728 Liberty Rd., Randallstown, Md. 21133							
		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)								Approximate Interval Between Onset and Death			
		a. CORONARY ARTERY DISEASE Due to (or as a consequence of):											
		b. Due to (or as a consequence of):											
		c. Due to (or as a consequence of):											
		d. Due to (or as a consequence of):											
		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown		23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown				23d. Date of delivery Month Day Year					
		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. HEPATIC FAILURE								23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown			
		25. Was case referred to medical examiner? 1 Yes 2 No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA				Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
		27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 Yes 2 No		28d. Describe how injury occurred			
		28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)									
		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.											
		29b. Signature and title of certifier 		29c. License number DS7722				29d. Date signed (Month, Day, Year) APRIL 15 2007					
		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LEONARD RICHARDSON M.D. 5401 OLD COURT ROAD, RANDALLSTOWN MD 21133											
State Registrar		31. Date filed (Month, Day, Year) APR 17 2007		32. Registrar's Signature 									

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 12172

1- For State Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>DEBRA STALLMAN</i>							2. Date of Death Month Day Year <i>APRIL 11 2007</i>	3. Time of Death Hour <i>223 PM</i>
	4a. Facility Name (If not institution, give street and number) <i>NORTHEAST HOSPITAL CENTER</i>			4b. City, Town, or Location of Death <i>RANDALLSTOWN</i>			4c. County of Death <i>BALTIMORE</i>		
Funeral Director	5. Social Security Number <i>218-72-7946</i>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 48 Yrs.	If Under 1 Year Months Days Hours Min.	8. Date of Birth (Month, Day, Year) <i>Apr. 10, 1959</i>	9. Birthplace (State or Foreign Country) <i>Maryland</i>		
	10a. State <i>MD</i>		10b. County <i>Baltimore</i>		10c. City, Town or Location <i>Reisterstown</i>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
To Be Completed by Funeral Director	10e. Street and Number <i>1309 Nicodemus Road</i>				10f. Zip Code <i>21136</i>		10g. Citizen of What Country? <i>United States</i>		
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: <i>If Yes, Give X</i>		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: <i>X</i>			14. Race - American Indian, Black, White, etc. Specify: <i>White</i>	
	15. Decedent's Education (Specify only highest grade completed) <i>Elementary/Secondary (0-12)</i>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>College (1-4 or 5+)</i>		16b. Kind of Business/Industry <i>Shipping Clerk</i>				
	17. Father's Name (First, Middle, Last) <i>Gerald Oldaker</i>				18. Mother's Name (First, Middle, Maiden Surname) <i>Phyllis Jaggie</i>				
	19a. Informant's Name/Relationship (Type, Print) <i>Romeo Stallman - Husband</i>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>1309 Nicodemus Rd., Reisterstown, MD 21136</i>				
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <i>Elkridge, MD</i>		20b. Place of Disposition (Name of Cemetery, Cemetery or other place) <i>Meadowridge Memorial Park</i>			Date <i>4-14-2007</i>	20c. Location - City or Town, State <i>Elkridge, MD</i>		
	21. Signature of Funeral Service Licensee <i>DANIELLA DAUGHERTY</i>		22. Name and Address of Facility <i>Ambrose Funeral Home, Inc.</i>						
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) <i>HEMORRHAGIC HYPOVOLMIC SHOCK</i>								
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <i>MASSIVE BLEEDING FROM UNRESECTABLE LUNG CANCER</i>								
	a. Due to (or as a consequence of): <i>UNRESECTABLE LUNG CANCER</i>								
	b. Due to (or as a consequence of): <i>MASSIVE BLEEDING FROM</i>								
	c. Due to (or as a consequence of): <i>HEMORRHAGIC HYPOVOLMIC SHOCK</i>								
	d. _____								
Physician /Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome pf pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year			
Medical Certification: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>None</i>						23e. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA			Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred <i>At home, farm, street, factory, office building, etc. (Specify)</i>			
						28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <i>NONE</i>			
	29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					29b. Signature and title of certifier <i>Orlando B. Conaway MD</i>			
						29c. License number <i>D 19502</i>	29d. Date signed (Month, Day, Year) <i>April 11, 2007</i>		
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Orlando B. Conaway MD</i>					31. Date filed (Month, Day, Year) <i>APR 17 2007</i>			
						32. Registrar's Signature <i>James B. Conaway</i>			

Baltimore, Maryland 21215-0036

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 12173

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Roy Lindbergh Simmons						2. Date of Death Month Day Year April 15, 2007	3. Time of Death 12:37 a M	
	4a. Facility Name (If not institution, give street and number) Carroll Hospital Center			4b. City, Town, or Location of Death Westminster			4c. County of Death Carroll		
Funeral Director	5. Social Security Number 219-22-8428	6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) 80 Yrs.	If Under 1 Year Months 1943-45	If Under 24 Hrs. Hours 0000	Min. 00	8. Date of Birth (Month, Day, Year) Nov. 10, 1926	9. Birthplace (State or Foreign Country) Maryland	
	10a. State MD			10b. County Baltimore			10c. City, Town or Location Reisterstown		
To Be Completed by Funeral Director	10e. Street and Number 220 Homevale Road			10f. Zip Code 21136			10g. Citizen of What Country? U.S.A.		
Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates 1943-45	13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:	14. Race - American Indian, Black, White, etc. White					
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Lithographer	16b. Kind of Business/Industry Printing						
	17. Father's Name (First, Middle, Last) Roy Lee Simmons	18. Mother's Name (First, Middle, Maiden Surname) Edith Robbins							
	19a. Informant's Name/Relationship (Type, Print) Kathi Gittere Daughter	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14001 Old Hanover Road Reisterstown, MD 21136							
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)	20b. Place of Disposition (Name of cemetery, crematory or other place) Evergreen Mem. Gard.	Date 4/18/07	20c. Location - City or Town, State Finksburg, MD					
	21. Signature of Funeral Service Licensee Stephen M. Jenkins	22. Name and Address of Facility ELINE FUNERAL HOME Reisterstown, MD 21136							
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Atherosclerotic Cardiovascular Disease Approximate Interval Between Onset and Death years								
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last { a. Due to (or as a consequence of): Hypertension b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):								
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown	23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify)	23d. Date of delivery Month Day Year						
Medical Certification: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Diabetes Mellitus Type II								
	23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown								
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								
	24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No								
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide	28a. Date of Injury (Month, Day Year) 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined	28b. Time of Injury M	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred				
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)								28f. Location (Street and Number or Rural Route Number, City or Town, State)
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician 2 <input type="checkbox"/> Medical Examiner	To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
	29b. Signature and title of certifier Jonathan Kushner MD	29c. License number D33184							
	29d. Date signed (Month, Day, Year) April 16, 2007								
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jonathan Kushner MD 114 Business Center Drive Reisterstown, MD 21136								
	31. Date filed (Month, Day, Year) APR 17 2007	32. Registrar's Signature Leanne B. Jones							

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

152
State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene
Certificate of Death

2007 12174

1- For State Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last)							2. Date of Death	3. Time of Death
	Lillian E. Simpson							Month Day Year Apr 10, 2007	2105 M
Funeral Director	4a. Facility Name (If not institution, give street and number)			4b. City, Town, or Location of Death			4c. County of Death		
	University Maryland Medical System			Baltimore			N/A		
To Be Completed by Funeral Director	5. Social Security Number		6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)	
	217-24-7236		<input type="checkbox"/> M <input checked="" type="checkbox"/> F	76 Yrs.	Months Days	Hours Min.	Aug 3, 1930	Maryland	
Usual Residence of Decedent		10a. State	10b. County	10c. City, Town or Location				10d. Inside City Limits	
		Maryland	N/A	Baltimore				<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number				10f. Zip Code			10g. Citizen of What Country?		
954 Seagull Avenue				21225			U.S.A.		
11. Marital Status		12. Was Decedent Ever in U.S. Armed Forces?			13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)			14. Race - American Indian, Black, White, etc.	
<input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:			<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			Specify: Black	
15. Decedent's Education (Specify only highest grade completed)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)			16b. Kind of Business/Industry		
Elementary/Secondary (0-12)		College (1-4 or 5+)		Education Assistant			Baltimore City Public School		
17. Father's Name (First, Middle, Last)				18. Mother's Name (First, Middle, Maiden Surname)					
Clinton Johnson				Lillian Green					
19a. Informant's Name/Relationship (Type, Print)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)					
Owen Nesmith Son				2606 Rittenhouse Avenue Baltimore, Maryland 21230					
20a. Method of Disposition		20b. Place of Disposition (Name of cemetery, crematory or other place)			Date	20c. Location - City or Town, State			
<input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		King Memorial Park			04/16/07	Windsor Mill, Md.			
21. Signature of Funeral Service Licensee		22. Name and Address of Facility							
<i>Eugene T. Walker Jr.</i>		Estep Brothers Funeral Service, P. A. 1300 Eutaw Place Baltimore, Md 21217							
26a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.									Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)									16 d
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last									
<p>a. Sepsis Due to (or as a consequence of): Complications of (R) Open Ankle Fracture Dislocation</p> <p>b. Fall Due to (or as a consequence of):</p> <p>c. Fall Due to (or as a consequence of):</p> <p>d. Fall Due to (or as a consequence of):</p>									
<p>IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown</p> <p>23c. If yes, outcome pf pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown</p>									23d. Date of delivery Month Day Year
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
ESRD, htn, DM, Hepatitis B, Atrial Fibrillation									24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
									24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one)							
		Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA			Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
27. Manner of Death <input type="checkbox"/> Natural <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred			
		3/5/2007		Unk	<input type="checkbox"/> Yes <input type="checkbox"/> No	Subject Fell			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State) 754 Seagull Ave Brooklyn, Md. 21225							
Home									
29a. Certifier (Check only one)		29b. Certification APPROVED BY MEDICAL EXAMINER							
<input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
29b. Signature and title of certifier <i>D. Nesmith</i>		29c. License number			29d. Date signed (Month, Day, Year)				
		17385			APRIL 16th 2007				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)		31. Date filed (Month, Day, Year)							
RTESEZIERO (R ADAMS COWLEY STC)		APR 17 2007							
32. Registrar's Signature		<i>Lillian B. Walker Jr.</i>							

Baltimore, Maryland 21215-0036

Permit: Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

S 5 To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 12175

1 - For
State
Registrar

Physician
/Medical
Examiner

Funeral
Director

To Be Completed by Funeral Director

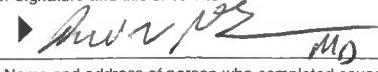
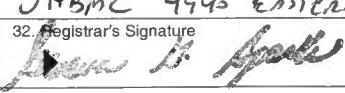
Baltimore, Maryland 21215-0036
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Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year				3. Time of Death			
<i>CLIFTON SCHREIBER</i>		April 13 2007				1330 M			
4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of Death				4c. County of Death			
<i>JOHNS HOPKINS BAYVIEW Medical Center</i>		<i>Baltimore MD</i>				<i>BALTIMORE CITY</i>			
5. Social Security Number		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 62 Yrs.	If Under 1 Year Months Days Hours Min.	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Oct. 14, 1944	9. Birthplace (State or Foreign Country) Maryland		
10a. State MD		10b. County N/A		10c. City, Town or Location Baltimore			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
10e. Street and Number 327 Hornet Street			10f. Zip Code 21224			10g. Citizen of What Country? USA			
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: White			14. Race - American Indian, Black, White, etc.		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Assembler			16b. Kind of Business/Industry General Motors			
17. Father's Name (First, Middle, Last) Clifton Schreiber				18. Mother's Name (First, Middle, Maiden Surname) Mary E. Bowers					
19a. Informant's Name/Relationship (Type, Print) Jean Schreiber- Wife			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 327 Hornet Street Baltimore, MD 21224						
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) Sacred Heart of Jesus			20b. Place of Disposition (Name of cemetery, crematory or other place) Sacred Heart of Jesus			Date 4/16/07	20c. Location - City or Town, State Dundalk, Maryland		
21. Signature of Funeral Service Licensee 			22. Name and Address of Facility Charles S Zeiler & Son 6224 Eastern Avenue Baltimore, MD 21224						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last			Approximate Interval Between Onset and Death Unknown						
<p>a. <i>LUNG TUMOR</i> Due to (or as a consequence of):</p> <p>b. Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. Due to (or as a consequence of):</p>									
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome pf pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown <input type="checkbox"/> Other (specify) _____				23d. Date of delivery Month Day Year			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>HEMOTOMA</i>							23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown		
							24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
							24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred			
		28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
29b. Signature and title of certifier 		29c. License number D44849			29d. Date signed (Month, Day, Year) APRIL 13, 2007				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RONALD PAULINE MD 148NC 4440 EASTERN AVE BALTIMORE MD 21224									
31. Date filed (Month, Day, Year) APR 17 2007		32. Registrar's Signature 							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 12176

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) George A. Timms, Sr.					2. Date of Death Month Day Year April 3, 2007	3. Time of Death 1:30PM M		
	4a. Facility Name (If not institution, give street and number) 5380 Sands Road		4b. City, Town, or Location of Death Lothian			4c. County of Death Anne Arundel			
Funeral Director	5. Social Security Number 578-20-1127	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 83 Yrs.	If Under 1 Year Months Days Hours Min.		8. Date of Birth (Month, Day, Year) Dec. 24, 1923	9. Birthplace (State or Foreign Country) Pennsylvania		
To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State Maryland 10b. County Anne Arundel 10c. City, Town or Location Lothian					10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
	10e. Street and Number 5380 Sands Road			10f. Zip Code 20711	10g. Citizen of What Country? U.S.A.				
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: WWII	13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	14. Race - American Indian, Black, White, etc. Specify: White					
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Minister	16b. Kind of Business/Industry Church Clergy						
	17. Father's Name (First, Middle, Last) Harry Timms			18. Mother's Name (First, Middle, Maiden Surname) Ellen Perkins					
	19a. Informant's Name/Relationship (Type, Print) George A. Timms (Son)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 310 Hooffs Run Drive Alexandria Virginia 22314						
Physician /Medical Examiner	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)	20b. Place of Disposition (Name of cemetery, crematory or other place) Maryland Veterans Cem.	Date April 10, 2007	20c. Location - City or Town, State Cheltenham, Maryland					
Medical Certification: To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee Dwight D. Dickey mo1284		22. Name and Address of Facility Lee Funeral Home, INC. 6633 Old Alexandria Ferry Road Clinton, MD 20735						
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)					Approximate Interval Between Onset and Death			
	a. Atherosclerotic Cardiovascular Disease Due to (or as a consequence of): Hypercholesterolemia								
	b. Due to (or as a consequence of):								
	c. Due to (or as a consequence of):								
	d. _____								
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown				23d. Date of delivery Month Day Year		
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)	28b. Time of Injury	M	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred		
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
	29b. Signature and title of certifier Joseph Randall, MD		29c. License number D42752			29d. Date signed (Month, Day, Year) 4/6/07			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)								
	Joseph Randall, MD 6104 Old Branch Avenue Temple Hills, Maryland 20748								
State Registrar	31. Date filed (Month, Day, Year) APR 17 2007	32. Registrar's Signature Joseph Randall							

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit slip.

Division of Vital Records, P.O. Box 68760,

12x1

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 12177

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Ruth V. Thomas							2. Date of Death Month Day Year April 14 2007	3. Time of Death 4:31 AM	
	4a. Facility Name (If not institution, give street and number) Union Memorial Hospital				4b. City, Town, or Location of Death Baltimore			4c. County of Death N/A		
Funeral Director	5. Social Security Number 218-30-5171	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 81 Yrs.	If Under 1 Year Months Days Hours Min. <input type="checkbox"/>	If Under 24 Hrs. <input type="checkbox"/>	8. Date of Birth (Month, Day, Year) Nov. 23, 1925	9. Birthplace (State or Foreign Country) Maryland			
To Be Completed by Funeral Director	10a. State Maryland				10b. County N/A			10c. City, Town or Location Baltimore		
	10e. Street and Number 1341 W. 37th Street				10f. Zip Code 21211			10g. Citizen of What Country? USA		
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: Year of Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: White			14. Race - American Indian, Black, White, etc. Specify: White		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker			16b. Kind of Business/Industry Own Home		
	17. Father's Name (First, Middle, Last) Herbert Hetrick				18. Mother's Name (First, Middle, Maiden Surname) Agnes Miller					
	19a. Informant's Name/Relationship (Type, Print) Robert McCarty Son-in-law				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1828 Redwood Avenue, Baltimore, Maryland 21234					
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) Lynn B. Henns				20b. Place of Disposition (Name of cemetery, crematory or other place) Loudon Park Cemetery			Date 4/17/2007	20c. Location - City or Town, State Baltimore, Maryland	
	21. Signature of Funeral Service Licensee Lynn B. Henns				22. Name and Address of Facility Burgee-Henns-Seitz Funeral Home, Inc. 21211 3631 Falls Road, Baltimore, Maryland					
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Acute Leukemia Approximate Interval Between Onset and Death 2 weeks									
	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Lymphoma Approximate Interval Between Onset and Death 3 months									
	23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown				23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown <input type="checkbox"/> Other (specify)			23d. Date of delivery Month Day Year		
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Acute Renal Failure Tumor LYSIS Syndrome									
	23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown									
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
	25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				26. Place of Death (Check only one) <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide				28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred	
					28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
	29b. Signature and title of certifier Jennifer Noznitsky, M.D.				29c. License number AT2438946			29d. Date signed (Month, Day, Year) April 14, 2007		
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Union Memorial Hospital				31. Date filed (Month, Day, Year) APR 17 2007			32. Registrar's Signature Susan K. Aponte		

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
 Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

1- For State Registrar Amend Item 24a, 25, 26, 27, 29a per dr. g866, 04/17/07dbb Amend Items 9, 11, 12, 13, 14, 15, 16a, b, 17, 18, 19a, b, c, &22 Certificate of Death 20a-g per dr. g866, 04/24/07dbb Reg. No. 2007-12178

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) John William Twiford				2. Date of Death Month Day Year March 28, 2007 9:15 AM M	3. Time of Death		
	4a. Facility Name (If not institution, give street and number) 18715 North Frederick Avenue #317		4b. City, Town, or Location of Death Gaithersburg		4c. County of Death Montgomery			
Funeral Director	5. Social Security Number 577-62-5628	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 60 Yrs.	If Under 1 Year Months Days Hours Min.	8. Date of Birth (Month, Day, Year) Nov 22, 1946	9. Birthplace (State or Foreign Country) Washington, DC		
	Usual Residence of Decedent 10a. State MD				10b. County Montgomery		10c. City, Town or Location Gaithersburg	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
To Be Completed by Funeral Director	10e. Street and Number 18715 North Frederick Avenue #317		10f. Zip Code 20879		10g. Citizen of What Country? USA			
	11. Marital Status <input checked="" type="checkbox"/> unk	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	13. Was Decedent of Hispanic Origin? (Specify Yes or No) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, specify Cuban, Mexican, Puerto Rican, etc. Year or Dates:	14. Race - American Indian, Black, White, etc. Specify: white				
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) unk College (1-4 or 5+) 10		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Shuttle Driver	16b. Kind of Business/Industry Maryland Shuttle	unk			
	17. Father's Name (First, Middle, Last) John C. Twiford				18. Mother's Name (First, Middle, Maiden Surname) Mary M. Henley			
	19a. Informant's Name/Relationship (Type, Print) Michelle L. Greenhill/Niece Montgomery County Police Dept				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9411 Quill Place, Montgomery Village, MD 20886			
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input checked="" type="checkbox"/> Other (Specify) in state		20b. Place of Disposition (Name of cemetery, crematory or other place) Metropolitan Crematory	Date 04/10/2007	20c. Location - City or Town, State Alexandria, VA			
	21. Signature of Funeral Service Licensee Ronald S. Wade, Director		22. Name and Address of Facility Collins Funeral Home Silver Spring State Anatomy Board 655 W. Baltimore Street Md. Baltimore, MD 21201 500 University Blvd 20901					
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							
Medical Certification: To Be Completed by Physician/Medical Examiner	<p>a. Pulmonary Embolism Due to (or as a consequence of):</p> <p>b. Congulopathy Due to (or as a consequence of):</p> <p>c. Hypertension, Diabetes Mellitus, Hyperlipidemia, Coronary artery Disease Due to (or as a consequence of):</p> <p>d. </p>							
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year		
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
	23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown							
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred		
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
	29b. Signature and title of certifier 		29c. License number D44239		29d. Date signed (Month, Day, Year) 3/30/07			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 16210 Frederick Rd #429 Gaithersburg MD 20877							
State Registrar	31. Date filed (Month, Day, Year) APR 17 2007	32. Registrar's Signature 						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2007 12179

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Lloyd P. Tyler							2. Date of Death Month Day Year April 9, 2007	3. Time of Death 6:40 PM	
	4a. Facility Name (If not institution, give street and number) Broadmead				4b. City, Town, or Location of Death Cockeysville			4c. County of Death Baltimore		
Funeral Director	5. Social Security Number 473-07-9571		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 91 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days Hours Min.	8. Date of Birth (Month, Day, Year) Aug 3, 1915	9. Birthplace (State or Foreign Country) Minnesota		
	Usual Residence of Decedent 10a. State MD		10b. County Baltimore	10c. City, Town or Location Cockeysville				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
10e. Street and Number 13801 York Road					10f. Zip Code 21030			10g. Citizen of What Country? USA		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: white			14. Race - American Indian, Black, White, etc. Specify: white		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) chemist			16b. Kind of Business/Industry unk					
17. Father's Name (First, Middle, Last) Charles Shirley Tyler					18. Mother's Name (First, Middle, Maiden Surname) Alice Louise Brown					
19a. Informant's Name/Relationship (Type, Print) Anne Modarressi/daughter					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 222 Tunbridge Road Baltimore, MD 21212					
20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) Ronald S. Wade, Director					20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last					Approximate Interval Between Onset and Death 5 min., 3 years					
<p>a. Due to (or as a consequence of): MYOCARDIAL INFARCTION</p> <p>b. Due to (or as a consequence of): ATRIAL FIBRILLATION</p> <p>c. Due to (or as a consequence of):</p> <p>d. _____</p>										
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown					23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Hypertension					23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown					
					24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide			28a. Date of Injury (Month, Day, Year) 28b. Time of Injury M 28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No 28d. Describe how injury occurred		
					28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
29b. Signature and title of certifier Cyrus Hamlin					29c. License number 050232			29d. Date signed (Month, Day, Year) 4/10/07		
30. Name and address of person who certified cause of death (Item 23a) (Type, Print) Cyrus Hamlin, MD 13801 York Rd Cockeysville, MD 21030					31. Date filed (Month, Day, Year) APR 17 2007			32. Registrar's Signature Reese & Park		

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

State
Registrar

Baltimore, Maryland 21215-0036

TYLER, LLOYD 4/9/07 6:40 PM

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

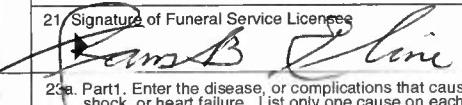
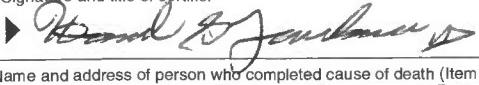
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2007 12180

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Bertha A. Turnbaugh					2. Date of Death Month Day Year April 12, 2007	3. Time of Death 9:05pm M	
	4a. Facility Name (If not institution, give street and number) Dove House Hospice Center			4b. City, Town, or Location of Death Westminster		4c. County of Death Carroll Co.		
Funeral Director	5. Social Security Number 213-18-7475	6. Sex 1 □ M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 85 Yrs.	If Under 1 Year Months 8	If Under 24 Hrs. Days 22	Hours 00	Min. 00	
	Usual Residence of Decedent			8. Date of Birth (Month, Day, Year) Dec. 22, 1921				9. Birthplace (State or Foreign Country) MD
To Be Completed by Funeral Director	10a. State MD	10b. County Carroll	10c. City, Town or Location Finksburg					10d. Inside City Limits 1 □ Yes <input checked="" type="checkbox"/> No
	10e. Street and Number 2213 Ridgemont Drive			10f. Zip Code 21048		10g. Citizen of What Country? USA		
11. Marital Status 1 □ Never Married 2 □ Married <input checked="" type="checkbox"/> Widowed 4 □ Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 □ Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Owner / Partner			16b. Kind of Business/Industry Motel Business		
17. Father's Name (First, Middle, Last) Clarence C. Trump, Sr.				18. Mother's Name (First, Middle, Maiden Surname) Annie C. Smith				
19a. Informant's Name/Relationship (Type, Print) Carole Ann Turnbaugh Daughter			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2213 Ridgemont Drive, Finksburg, MD 21048					
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Evergreen Memorial			Date 4/16/07	20c. Location - City or Town, State Finksburg, MD		
21. Signature of Funeral Service Licensee 			22. Name and Address of Facility 11824 Reisterstown Road Eline Funeral Home Reisterstown, MD 21136					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								
<p>a. Congestive heart failure Due to (or as a consequence of):</p> <p>b. _____ Due to (or as a consequence of):</p> <p>c. _____ Due to (or as a consequence of):</p> <p>d. _____</p>								
Approximate Interval Between Onset and Death 2 months								
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown			3 □ Ectopic pregnancy 5 □ Other (specify) _____	23d. Date of delivery Month Day Year		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								
Pulmonary hypertension 4 years								
Sleep apnea								
25. Was case referred to medical examiner? 1 □ Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 □ Inpatient 2 □ ER/Outpatient 3 □ DOA Other: 4 □ Nursing Home 5 □ Residence 6 <input checked="" type="checkbox"/> Other (Specify) Hospice						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 □ Pending investigation 2 □ Accident 6 □ Could not be determined 3 □ Suicide 4 □ Homicide		28a. Date of Injury (Month, Day Year) M		28b. Time of Injury M		28c. Injury at Work? 1 □ Yes 2 □ No	28d. Describe how injury occurred 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier 		29c. License number D17040			29d. Date signed (Month, Day, Year) April 13, 2007			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Howard G. Lanham, M.D. 215 Washington Heights Medical Center								
31. Date filed (Month, Day, Year) APR 17 2007		32. Registrar's Signature  Westminster, MD 21157						

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
 Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007

12181

Physician /Medical Examiner Funeral Director		<p>1. Decedent's Name (First, Middle, Last) Ralph Napoleon Therien</p> <p>4a. Facility Name (If not institution, give street and number) Gilchrist Hospice</p> <p>5. Social Security Number 038-18-5234 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F 7. Age (In yrs. last birthday) 76 Yrs.</p> <p>10a. State MD 10b. County Baltimore 10c. City, Town or Location Parkville</p> <p>10e. Street and Number 8415 Old Harford Road 10f. Zip Code 21234 10g. Citizen of What Country? USA</p> <p>11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced 12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: 1951-53 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: White 14. Race - American Indian, Black, White, etc. Specify: White</p> <p>15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Insurance Agent 16b. Kind of Business/Industry Insurance</p> <p>17. Father's Name (First, Middle, Last) George Henry Therien 18. Mother's Name (First, Middle, Maiden Surname) Amanda Levesque</p> <p>19a. Informant's Name/Relationship (Type, Print) Dawn Therien/wife 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8415 Old Harford Rd. Parkville, MD 21234</p> <p>20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) Chesapeake Crematory Date 04/17/07 20c. Location - City or Town, State Beltsville, MD</p> <p>21. Signature of Funeral Service Licensee Beverly L. Heckrotte</p>					
To Be Completed by Physician/Medical Examiner Medical Certification: To Be Completed by Physician/Medical Examiner		<p>23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</p> <p>a. Due to (or as a consequence of): lung cancer</p> <p>b. Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. Due to (or as a consequence of):</p> <p>Approximate Interval Between Onset and Death months</p> <p>IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown 23c. If yes, outcome pf pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown <input type="checkbox"/> Other (specify) _____ 23d. Date of delivery Month Day Year</p> <p>Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.</p> <p>23e. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown</p> <p>24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) Hospice</p> <p>27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined 28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No 28d. Describe how injury occurred</p> <p>28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)</p> <p>28f. Location (Street and Number or Rural Route Number, City or Town, State)</p> <p>29a. Certifier <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.</p> <p>29b. Signature and title of certifier Helen M. Gordon 29c. License number DOO51926 29d. Date signed (Month, Day, Year) 4/14/07</p> <p>30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Helen M. Gordon 6565 N. Charles St., Baltimore MD 21204</p> <p>31. Date filed (Month, Day, Year) APR 17 2007 32. Registrar's Signature Laura B. Spuler</p>					

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

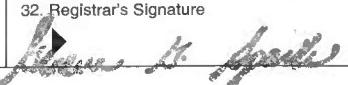
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2007 12182

1 - For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) DAVID TISSENBAUM				2. Date of Death Month APRIL Day 14 Year 2007	3. Time of Death 9:33 AM
	4a. Facility Name (If not institution, give street and number) SINAI HOSPITAL OF BALTIMORE		4b. City, Town, or Location of Death BALTIMORE CITY		4c. County of Death N/A	
Funeral Director	5. Social Security Number 219-01-5029	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 88 Yrs.	If Under 1 Year Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. 8. Date of Birth (Month, Day, Year) 06/29/1918	9. Birthplace (State or Foreign Country) MD	
To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State MD 10b. County N/A			10c. City, Town or Location BALTIMORE		
	10e. Street and Number 3634 FORDS LANE			10f. Zip Code 21215	10g. Citizen of What Country? U.S.A.	
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: 14. Race - American Indian, Black, White, etc. Specify: WHITE		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 4 College (1-4 or 5+) 4		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) OWNER		16b. Kind of Business/Industry DELUXE SADDLERY	
	17. Father's Name (First, Middle, Last) SAMUEL TISSENBAUM			18. Mother's Name (First, Middle, Maiden Surname) BLANCHE BLOOM		
	19a. Informant's Name/Relationship (Type, Print) RICHARD LAKEIN / NEPHEW			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8711 BUNNELL DRIVE - POTOMAC, MD 20854		
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) BETH TFILOH CONG.		20b. Place of Disposition (Name of cemetery, crematory or other place) BETH TFILOH CONG.	Date 04/15/2007	20c. Location - City or Town, State WOODLAWN, MD	
	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208			
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) RT apical lung mass					Approximate Interval Between Onset and Death
	b. Due to (or as a consequence of): HEMOPTYSIS					
	c. Due to (or as a consequence of):					
	d. Due to (or as a consequence of):					
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome pf pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) _____ 9 <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year	
Medical Certification: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CRI HTN CAD					23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DCA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year) M	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
			28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred	
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29b. Signature and title of certifier 		29c. License number D0063170		29d. Date signed (Month, Day, Year) APRIL 14 2007	
State Registrar	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SYED RIZVI, Sinai Hospital of Baltimore		31. Date filed (Month, Day, Year) APR 17 2007 32. Registrar's Signature 			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 12183

1- For State Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) NORMAN DAVID TAYLOR					2. Date of Death Month APRIL Day 12 Year 2007	3. Time of Death 09:02 AM
	4a. Facility Name (If not institution, give street and number) LEVINDALE HEBREW HOME			4b. City, Town, or Location of Death BALTIMORE		4c. County of Death N/A	
Funeral Director	5. Social Security Number 219-18-1071	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 79 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Hours	8. Date of Birth (Month, Day, Year) 11/13/1927	9. Birthplace (State or Foreign Country) MD
	Usual Residence of Decedent 10a. State MD 10b. County BALTIMORE			10c. City, Town or Location OWINGS MILLS			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
To Be Completed by Funeral Director	10e. Street and Number 8 D NOBILITY COURT			10f. Zip Code 21117		10g. Citizen of What Country? U.S.A.	
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: WWII NAVY		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) INVESTIGATOR		16b. Kind of Business/Industry STATE OF MARYLAND INSURANCE COMMISSION		
	17. Father's Name (First, Middle, Last) BENJAMIN TAYLOR			18. Mother's Name (First, Middle, Maiden Surname) IDA CUTLER			
	19a. Informant's Name/Relationship (Type, Print) SUE ELLEN TAYLOR / WIFE			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8 D NOBILITY COURT - OWINGS MILLS, MD 21117			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) OHEB SHALOM MEMORIAL PARK			Date 04/15/2007	20c. Location - City or Town, State REISTERSTOWN, MD.		
	21. Signature of Funeral Service Licensee Matt L.			22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208			
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) ASPIRATION PNEUMONIA Approximate Interval Between Onset and Death 2 days						
	23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown						
	23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____						
	23d. Date of delivery Month Day Year						
Medical Certification: To Be Completed by Physician/Medical Examiner	23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown						
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						
	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						
	26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) _____						
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred	
	28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)						
	28f. Location (Street and Number or Rural Route Number, City or Town, State)						
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier Regina, MD				
	29c. License number D0053928		29d. Date signed (Month, Day, Year) 04/12/2007				
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2434 W. BELVEDERE AVE, BALTIMORE, MD 21215		31. Date filed (Month, Day, Year) APR 17 2007 32. Registrar's Signature Janet J. Spotts				

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 12184

1- For State Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Catherine Mary Van Sickle				2. Date of Death Month April Day 15 Year 2007	3. Time of Death 9:15 PM		
	4a. Facility Name (If not institution, give street and number) Baltimore Washington Medical Center		4b. City, Town, or Location of Death Glen Burnie		4c. County of Death Anne Arundel			
Funeral Director	5. Social Security Number 217-24-2688	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 79 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Nov. 13, 1927	9. Birthplace (State or Foreign Country) MD	
	Usual Residence of Decedent 10a. State MD 10b. County Anne Arundel				10c. City, Town or Location Severna Park			10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
To Be Completed by Funeral Director	10e. Street and Number 457 Yorkshire Drive			10f. Zip Code 21146		10g. Citizen of What Country? U.S.A.		
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Homemaker		16b. Kind of Business/Industry Own Home			
	17. Father's Name (First, Middle, Last) George Scott Miller				18. Mother's Name (First, Middle, Maiden Surname) Mary Eva Smith			
	19a. Informant's Name/Relationship (Type, Print) Mrs Deborah Michael/ Daughter			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7644 4th Street Pasadena, MD 21122		20c. Location - City or Town, State Glen Burnie, MD		
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Glen Haven Mem. Park		Date April 18, 2007			
	21. Signature of Funeral Service Licensee, Selena Shuk M01479							
	22. Name and Address of Facility Singleton Funeral Home, P.A. 1 Second Avenue SW Glen Burnie, MD 21061							
Physician /Medical Examiner	<p>23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.</p> <p>Immediate Cause (Final disease or condition resulting in death)</p> <p>COLON CANCER</p> <p>Approximate Interval Between Onset and Death 1 month</p> <p>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</p> <p>DEMENTIA</p> <p>5 YEARS</p> <p>a. Due to (or as a consequence of): COLON CANCER</p> <p>b. Due to (or as a consequence of): DEMENTIA</p> <p>c. Due to (or as a consequence of):</p> <p>d. Due to (or as a consequence of):</p>							
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify)				23d. Date of delivery Month Day Year	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
	<p>23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown</p> <p>24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</p> <p>24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p>							
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No							
	<p>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)</p> <p>26. Place of Death (Check only one)</p>							
	<p>27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide</p> <p>5 <input type="checkbox"/> Pending investigation</p> <p>6 <input type="checkbox"/> Could not be determined</p> <p>28a. Date of Injury (Month, Day, Year)</p> <p>28b. Time of Injury M</p> <p>28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</p> <p>28d. Describe how injury occurred</p>							
	<p>28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)</p> <p>28f. Location (Street and Number or Rural Route Number, City or Town, State)</p>							
	<p>29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.</p> <p>29b. Signature and title of certifier GEORGE BAFFEE-BONNIE, MD</p> <p>29c. License number D 0059190</p> <p>29d. Date signed (Month, Day, Year) APRIL 15 2007</p>							
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GEORGE BAFFEE-BONNIE, MD BALTIMORE WASHINGTON MEDICAL CENTER							
State Registrar	31. Date filed (Month, Day, Year) APR 17 2007		32. Registrar's Signature James B. Bafile					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Amend #30 perDVR, g866, 4/17/07 TT

Certificate of Death

Reg. No. *2007 12185*

Physician /Medical Examiner		1. Decedent's Name (First, Middle, Last) Rose Ann Wilson						2. Date of Death Month Day Year April 15, 2007		3. Time of Death 9: 15 AM	
Funeral Director		4a. Facility Name (If not institution, give street and number) 6720 Graceland Avenue						4b. City, Town, or Location of Death Baltimore		4c. County of Death N/A	
To Be Completed by Funeral Director		5. Social Security Number 183-34-0818		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 62 Yrs.		If Under 1 Year Months Days Hours Min. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		8. Date of Birth (Month, Day, Year) September 24, 1944	
To Be Completed by Physician/Medical Examiner		9. Birthplace (State or Foreign Country) Pennsylvania									
To Be Completed by Physician/Medical Examiner		10a. State Maryland		10b. County N/A		10c. City, Town or Location Baltimore				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner		10e. Street and Number 6720 Graceland Avenue				10f. Zip Code 21224		10g. Citizen of What Country? USA			
To Be Completed by Physician/Medical Examiner		11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: Year		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: White		14. Race - American Indian, Black, White, etc. Specify: White			
To Be Completed by Physician/Medical Examiner		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 years		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 2 years Housewife		16b. Kind of Business/Industry Own Home					
To Be Completed by Physician/Medical Examiner		17. Father's Name (First, Middle, Last) Walter Eugene Mc Caskey				18. Mother's Name (First, Middle, Maiden Surname) Velma Loretta Beck					
To Be Completed by Physician/Medical Examiner		19a. Informant's Name/Relationship (Type, Print) David Wilson Husband		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6720 Graceland Avenue, Baltimore, Maryland 21224							
To Be Completed by Physician/Medical Examiner		20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) Bayview Crematory		20b. Place of Disposition (Name of cemetery, crematory or other place) Bayview Crematory		Date April 17, 2007		20c. Location - City or Town, State Baltimore Maryland			
To Be Completed by Physician/Medical Examiner		21. Signature of Funeral Service License Anthony Connolly		22. Name and Address of Facility Connolly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, MD. 21222				Approximate Interval Between Onset and Death 1 yr			
To Be Completed by Physician/Medical Examiner		23a. Part 1. Enter the disease(s) or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		23b. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown <input type="checkbox"/> Other (specify) Unknown				23d. Date of delivery Month Day Year			
To Be Completed by Physician/Medical Examiner		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown <input type="checkbox"/> Other (specify) Unknown		23d. Date of delivery Month Day Year							
To Be Completed by Physician/Medical Examiner		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
To Be Completed by Physician/Medical Examiner		23f. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
To Be Completed by Physician/Medical Examiner		25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
To Be Completed by Physician/Medical Examiner		27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred	
To Be Completed by Physician/Medical Examiner		28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State)			
To Be Completed by Physician/Medical Examiner		29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29c. License number DC-60555				29d. Date signed (Month, Day, Year) 4/16/07			
To Be Completed by Physician/Medical Examiner		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jean Michelle Toppin, MD, Baltimore, MD									
State Registrar		31. Date filed (Month, Day, Year) APR 17 2007		32. Registrar's Signature Sten B. Apoth							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2007 12186

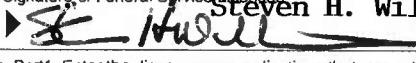
Reg. No.

1- For
State
RegistrarPhysician
/Medical
ExaminerFuneral
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
 Important: If item 27 is marked other than "natural", or items 23a or 28e-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

		1. Decedent's Name (First, Middle, Last)						2. Date of Death Month Day Year			3. Time of Death	
		Frederick W. Warwick						April 14 2007			1:30 a M	
		4a. Facility Name (If not institution, give street and number)			4b. City, Town, or Location of Death			4c. County of Death				
		Charlestown Care Center			Catonsville			Baltimore				
		5. Social Security Number		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 86 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) JUN 11 1920	9. Birthplace (State or Foreign Country) MA			
		10a. State MD		10b. County Baltimore		10c. City, Town or Location Catonsville			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
		10e. Street and Number 713 Maiden Choice Lane, Apt. 2311				10f. Zip Code 21228			10g. Citizen of What Country? USA			
		11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: WWII		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White			
		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 4		16b. Kind of Business/Industry Chemical Engineer			17. Father's Name (First, Middle, Last) Frederick W. Warwick			
		18. Mother's Name (First, Middle, Maiden Surname) Elvira Kessel		19a. Informant's Name/Relationship (Type, Print) Jean M. Warwick - wife		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 713 Maiden Choice Lane, Apt. 2311, Catonsville, MD 21228						
		20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place)		Date			20c. Location - City or Town, State Metro Crematory, Inc. 4/16/2007 Baltimore, MD			
		21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Cremation Society of Maryland, Inc. 299 Frederick Road, Baltimore, MD 21228								
		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Cardiovascular</i>		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____ <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year			
		23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown										
		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
		25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOD Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
		27. Manner of Death 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		
		5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State)		
		29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
		29b. Signature and title of certifier 		29c. License number 10020040		29d. Date signed (Month, Day, Year) 4/14/07						
		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jean M. Warwick, 713 Maiden Choice Lane, Catonsville, MD 21228										
		31. Date filed (Month, Day, Year) APR 17 2007		32. Registrar's Signature 								

ORIGINAL

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 12187

1- For State
Registrar

1. Decedent's Name (First, Middle, Last)

Richard Roland Wilson

2. Date of Death

Month April

Day 10

Year 2007

3. Time of Death

1516 hrs

Physician/
Medical ExaminerFuneral
Director

To Be Completed by Funeral Director

Baltimore, MD 21215-0035

Important: If item 27 is marked other than "natural", or items 23a or 28a show any injury or other traumatic event, the Medical Examiner must be notified at once.

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit

Medical Certification: To Be Completed by Physician/Medical Examiner

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 12188

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) John G. Wilmoth					2. Date of Death Month 04 Day 15 Year 2007	3. Time of Death 11:03 AM	
	4a. Facility Name (If not institution, give street and number) Franklin Square Hospital			4b. City, Town, or Location of Death Rosedale		4c. County of Death Baltimore		
Funeral Director	5. Social Security Number 212-62-9726	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 52 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days Hours Min.	8. Date of Birth (Month, Day, Year) March 25, 1955	9. Birthplace (State or Foreign Country) Maryland	
To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State MD 10b. County Baltimore 10c. City, Town or Location Middle River					10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
	10e. Street and Number 1212 Susquehanna Avenue			10f. Zip Code 21220		10g. Citizen of What Country? USA		
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Sales		16b. Kind of Business/Industry Marine			
	17. Father's Name (First, Middle, Last) Earl N. Wilmoth Sr.				18. Mother's Name (First, Middle, Maiden Surname) Julia C. Costello			
	19a. Informant's Name/Relationship (Type, Print) Brenda H. Wilmoth /wife			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1212 Susquehanna Avenue Baltimore MD 21220				
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Gardens of Faith		Date 4/20/07	20c. Location - City or Town, State Rossville MD	
	21. Signature of Funeral Service Licensee Patrick R. Perry			22. Name and Address of Facility 300 Mace Ave. Balto. MD Connelly Funeral Home of Essex 21221				
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							
Medical Certification: To Be Completed by Physician/Medical Examiner	<p>a. Due to (or as a consequence of): Acute Myocardial Infarction</p> <p>b. Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. Due to (or as a consequence of):</p>							
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown			23c. If yes, outcome pf pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown				23d. Date of delivery Month Day Year
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Metastatic Esophageal Cancer							
	23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown							
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
	26. Place of Death Check only one Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred	
	28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)							
	28f. Location (Street and Number or Rural Route Number, City or Town, State)							
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
	29b. Signature and title of certifier Nona P. Novello MD							
	29c. License number DS4702							
	29d. Date signed (Month, Day, Year) 4/16/2007							
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Nona P. Novello 9000 Franklin Square Drive Balto, MD 21237							
	31. Date filed (Month, Day, Year) APR 17 2007		32. Registrar's Signature James A. Jones					

Division or Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2017 12189

Physician /Medical Examiner		1. Decedent's Name (First, Middle, Last) Carroll H. Wise, Sr.						2. Date of Death Month Day Year April 16, 2007		3. Time of Death 6:40 A M			
Funeral Director		4a. Facility Name (If not institution, give street and number) Upper Chesapeake Medical Center			4b. City, Town, or Location of Death Bel Air				4c. County of Death Harford				
To Be Completed by Funeral Director		5. Social Security Number 219-10-7466		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs, last birthday) 79 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	Hours	Min.	8. Date of Birth (Month, Day, Year) April 20, 1927	9. Birthplace (State or Foreign Country) Maryland		
		Usual Residence of Decedent		10a. State Maryland		10b. County Harford		10c. City, Town or Location BE1 Air				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
		10e. Street and Number 604 F Churchill Rd						10f. Zip Code 21014		10g. Citizen of What Country? U.S.A.			
		11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White			
		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Police Officer			16b. Kind of Business/Industry Baltimore City						
		17. Father's Name (First, Middle, Last) Albert Wise					18. Mother's Name (First, Middle, Maiden Surname) Daisy Roberts						
		19a. Informant's Name/Relationship (Type. Print) Patricia Rubin (Daughter)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2001 Hillcroft Drive Forest Hill, MD 21050									
		20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) Bayview Crematory		20b. Place of Disposition (Name of cemetery, crematory or other place) Bayview Crematory			Date 04-20-2007	20c. Location - City or Town, State Baltimore, Maryland					
21. Signature of Funeral Service Licensee Diane Rineker		22. Name and Address of Facility Schimunek Funeral Home of Bel Air Inc. 610 W. MacPhail Rd., Bel Air, MD., 21014											
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		23b. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Underlying Cause (Disease or injury that initiated events resulting in death) Last			23c. If yes, outcome pf pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown 3 <input type="checkbox"/> Ectopic pregnancy 5 <input type="checkbox"/> Other (specify) _____			23d. Date of delivery Month Day Year					
23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		23f. Approximate Interval Between Onset and Death											
23g. IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23h. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. NIDDM, HTN, Aortic stenosis, PFO, venous insuff			23i. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown								
23j. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		23k. Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA			23l. Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			23m. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
23n. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		23o. Date of Injury (Month, Day Year)			23p. Time of Injury M		23q. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		23r. Describe how injury occurred				
23s. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		23t. Place of injury - At home, farm, street, factory, office building, etc. (Specify)			23u. Location (Street and Number or Rural Route Number, City or Town, State)								
23v. Signature and title of certifier Aprya Desai		23w. License number DC63072			23x. Date signed (Month, Day, Year) April 16, 2007								
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Apurva Desai		31. Date filed (Month, Day, Year) APR 17 2007			32. Registrar's Signature John B. Spangler								

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**State
egistrar**

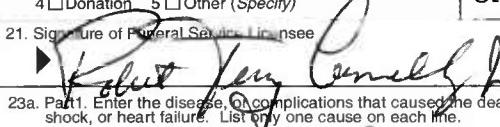
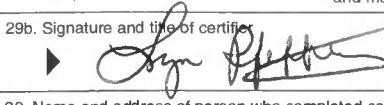
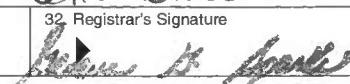
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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 12190

1- For State Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) John Harrison Webb							2. Date of Death Month: April Day: 13 Year: 2007	3. Time of Death 4:45PM		
	4a. Facility Name (If not institution, give street and number) 505 North Stuart Street			4b. City, Town, or Location of Death Essex			4c. County of Death Baltimore				
Funeral Director	5. Social Security Number 217-09-5913	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 86 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) Dec. 11, 1920	9. Birthplace (State or Foreign Country) Maryland				
To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State MD 10b. County Baltimore 10c. City, Town or Location Essex							10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
	10e. Street and Number 505 North Stuart Street			10f. Zip Code 21221			10g. Citizen of What Country? USA				
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: White			14. Race - American Indian, Black, White, etc. Specify: White				
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 6th			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Supervisor			16b. Kind of Business/Industry Aircraft				
	17. Father's Name (First, Middle, Last) Charles W. Webb				18. Mother's Name (First, Middle, Maiden Surname) Elizabeth McCracken						
	19a. Informant's Name/Relationship (Type. Print) Lois Cook /daughter			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 412 Dorsey Avenue Baltimore MD 21221							
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Oak Lawm Cemetery			Date 4/17/07	20c. Location - City or Town, State Baltimore MD			
	21. Signature of Funeral Service Incense 			22. Name and Address of Facility 300 Mace Ave. Balto. MD Connelly Funeral Home of Essex 21221							
	23a. Enter the disease, complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Coronary Artery Disease								Approximate Interval Between Onset and Death		
	23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown								IF FEMALE: 23c. If yes, outcome pf pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown	23d. Date of delivery Month Day Year	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Hypertension								23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide								28a. Date of Injury (Month, Day Year) M 28b. Time of Injury M 28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred	
	28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)								28f. Location (Street and Number or Rural Route Number, City or Town, State)		
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
	29b. Signature and title of certifier 								29c. License number D35410	29d. Date signed (Month, Day, Year) April 16, 2007	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Lyn Pfleider 6918 Ridge Rd Baltimore, MD 21237										
State Registrar	31. Date filed (Month, Day, Year) APR 17 2007			32. Registrar's Signature 							

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

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To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 12191

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) DONG Wu						2. Date of Death Month APRIL Day 06 Year 2007			3. Time of Death A 10:22 M	
	4a. Facility Name (If not institution, give street and number) BALTIMORE WASHINGTON MEDICAL CENTER			4b. City, Town, or Location of Death GLEN BURNIE			4c. County of Death ANNE ARUNDEL				
Funeral Director	5. Social Security Number N/A		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 58 Yrs.	If Under 1 Year Months 0 Days 0		If Under 24 Hrs. Hours 0 Min. 0		8. Date of Birth (Month, Day, Year) 6/20/1948	9. Birthplace (State or Foreign Country) CHINA	
	Usual Residence of Decedent 10a. State MD 10b. County ANNE ARUNDEL 10c. City, Town or Location ODENTON 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										
10e. Street and Number 954 CITRINE WAY					10f. Zip Code 21113			10g. Citizen of What Country? CHINA			
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: Specify: ASIAN			14. Race - American Indian, Black, White, etc. Specify: ASIAN			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 4 UNIVERSITY PROFESSOR			16b. Kind of Business/Industry QING-DAO OCEAN UNIVERSITY					
17. Father's Name (First, Middle, Last) ZIKANG DONG					18. Mother's Name (First, Middle, Maiden Surname) HUAIYING WU						
19a. Informant's Name/Relationship (Type, Print) QIAN LIANG ZHANG - HUSBAND				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 954 CITRINE WAY, ODENTON, MD 21113							
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) CHESAPEAKE CREMATION			20b. Place of Disposition (Name of cemetery, crematory or other place) CHESAPEAKE CREMATION			Date 4/15/2007	20c. Location - City or Town, State STEVENSVILLE, MD				
21. Signature of Funeral Service Licensee J. Dong			22. Name and Address of Facility SINGLETON FUNERAL HOME P.A. 1 SECOND AVE. S.W., GLEN BURNIE, MD 21061								
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Stroke Approximate Interval Between Onset and Death 1 day											
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last { a. Due to (or as a consequence of): Stroke b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):											
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Unknown						23d. Date of delivery Month Day Year			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. metastatic renal cancer											
23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown											
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No											
26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)											
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred					
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier Charles S. Wiles MD									
		29c. License number D 24285			29d. Date signed (Month, Day, Year) April 06, 2007						
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Charles S. Wiles MD											
31. Date filed (Month, Day, Year) APR 17 2007		32. Registrar's Signature Charles S. Wiles MD									

Division or Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036
Wu, Dong
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.Division or Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transitState
Registrar

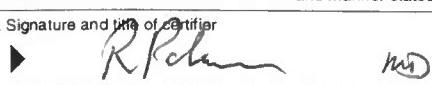
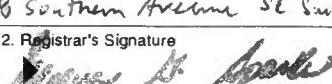
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 12192

1 - For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) WILLIE G. WALL							2. Date of Death Month 04	Day 12	Year 2007	3. Time of Death 13:15 M
	4a. Facility Name (If not institution, give street and number) FORT WASHINGTON HOSPITAL				4b. City, Town, or Location of Death FORT WASHINGTON			4c. County of Death PRINCE GOERGES			
Funeral Director	5. Social Security Number 578 36 0171	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 79 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month Day Year) 12-5-1927	9. Birthplace (State or Foreign Country) SC				
	Usual Residence of Decedent 10a. State MD 10b. County PRINCE GEORGES				10c. City, Town or Location FORT WASHINGTON			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
To Be Completed by Funeral Director	10e. Street and Number 12021 LIVINGSTON ROAD				10f. Zip Code 20744			10g. Citizen of What Country? USA			
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: BLACK			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) ELECTRICIAN			16b. Kind of Business/Industry FEDERAL GOVERNMENT			
	17. Father's Name (First, Middle, Last) BENJAMIN WALL				18. Mother's Name (First, Middle, Maiden Surname) ADA BETHEA						
	19a. Informant's Name/Relationship (Type, Print) GWENDOLYN BAILY/GRANDDAUGHTER				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1472 POTOMAC HEIGHTS DR, FT. WASHINGTON, MD 20744						
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) HARMONY MEMORIAL		Date 4-19-2007	20c. Location - City or Town, State LANDOVER, MD					
	21. Signature of Funeral Service Licensee 		22. Name and Address of Funeral Home MARSHALL'S FUNERAL HOME OF MD, INC. 4308 SUITLAND RD, SUITLAND, MD 20746								
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <i>Acute myocardial infarction</i> Due to (or as a consequence of): _____								Approximate Interval Between Onset and Death		
Physician /Medical Examiner	b. _____ Due to (or as a consequence of): _____										
Physician /Medical Examiner	c. _____ Due to (or as a consequence of): _____										
Physician /Medical Examiner	d. _____										
Physician /Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year					
Physician /Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
Physician /Medical Examiner									24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Physician /Medical Examiner	25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No								26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		
Physician /Medical Examiner	27. Manner of Death 1 <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide <input type="checkbox"/> Determined 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury	28c. Injury at Work? M <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred				
Physician /Medical Examiner	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)								28f. Location (Street and Number or Rural Route Number, City or Town, State)		
Physician /Medical Examiner	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								29b. Signature and title of certifier 	29c. License number D0055120	29d. Date signed (Month, Day, Year) April 12 2007
Physician /Medical Examiner	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Richard Palmer MD 1328 Southern Avenue SE Suite 510 Washington DC 20032								31. Date filed (Month, Day, Year) APR 17 2007		32. Registrar's Signature 

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

perm. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified once.

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 12193

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>Reginald Wilson</i>				2. Date of Death Month Day Year <i>4 - 12 - 2007</i>	3. Time of Death <i>6:30PM</i>		
	4a. Facility Name (if not institution, give street and number) <i>Genesis Catonsville Commons</i>		4b. City, Town, or Location of Death <i>Baltimore</i>		4c. County of Death <i>Baltimore County</i>			
Funeral Director	5. Social Security Number <i>212-56-3216</i>	6. Sex <input checked="" type="checkbox"/> X <input type="checkbox"/> F	7. Age (In yrs. last birthday) <i>55 Yrs.</i>	If Under 1 Year Months Days Hours Min. <i></i>	If Under 24 Hrs. <i></i>	8. Date of Birth (Month, Day, Year) <i>Sep 17, 1951</i>	9. Birthplace (State or Foreign Country) <i>Maryland</i>	
To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State <i>Maryland</i> 10b. County <i>Baltimore</i> 10c. City, Town or Location <i>Owings Mills</i>						10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
	10e. Street and Number <i>17 Devon Court</i>			10f. Zip Code <i>21117</i>		10g. Citizen of What Country? <i>U.S.A.</i>		
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: <i></i>		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: <i></i>		14. Race - American Indian, Black, White, etc. Specify: <i>Black</i>		
	15. Decedent's Education (Specify only highest grade completed) <i>Elementary/Secondary (0-12)</i>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>College (1-4 or 5+)</i> <i>Janitor</i>		16b. Kind of Business/Industry <i>My Clean Company</i>			
	17. Father's Name (First, Middle, Last) <i>Unknown</i>				18. Mother's Name (First, Middle, Maiden Surname) <i>Laura Isom</i>			
	19a. Informant's Name/Relationship (Type. Print) <i>Desiree Wheeler</i>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>17 Devon Court Owings Mills, Maryland 21117</i>				
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <i></i>		20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Woodlawn Cemetery & Chapel</i>		Date <i>04/18/07</i>	20c. Location - City or Town, State <i>Baltimore, Md.</i>		
Physician /Medical Examiner	21. Signature of Funeral Service Licensee <i>Lloyd M. Estep</i>		22. Name and Address of Facility <i>Estep Brothers Funeral Service, P. A. 1300 Eutaw Place Baltimore, Md 21217</i>					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <i>Metastatic lung cancer</i>		Approximate Interval Between Onset and Death <i></i>					
	23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown <input type="checkbox"/> Other (specify) <i></i>		23d. Date of delivery Month Day Year			
Medical Certification: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown			
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) <i></i>					
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)	28b. Time of Injury <i>M</i>	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred		
			28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) <i></i>		28f. Location (Street and Number or Rural Route Number, City or Town, State) <i></i>			
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
	29b. Signature and title of certifier <i>Jocelyn N. El-Sayed, MD, MPH</i>		29c. License number <i>DOOSG6414</i>		29d. Date signed (Month, Day, Year) <i>4-13-2007</i>			
State Registrar	31. Date filed (Month, Day, Year) <i>APR 17 2007</i>		32. Registrar's Signature <i>Jocelyn N. El-Sayed</i>					

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

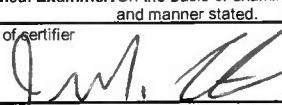
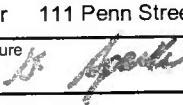
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 12194

1- For State
Registrar

Physician/ Medical Examiner	1. Decedent's Name (First, Middle, Last) Brian Matthew Weeden					2. Date of Death Month April Day 13, Year 2007	3. Time of Death 1846 hrs
	4a. Facility Name (if not institution, give street and number) 9302 Millbrook Road			4b. City, Town, or Location of Death Ellicott City		4c. County of Death Howard	
Funeral Director	5. Social Security Number 213.23.6201	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 18 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth(MM/DD/YYYY) 11/30/1988	9. Birthplace (State or Foreign Country) MD
	Usual Residence of Decedent 10a. State MD			10b. County Howard			10c. City, Town or Location Ellicott City
10e. Street and Number 9302 Millbrook Rd.				10f. Zip Code 21042		10g. Citizen of What Country? USA	
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No specify:			14. Race - American Indian, Black, White, etc. White
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) unemployed			16b. Kind of Business/Industry unemployed	
17. Father's Name (First, Middle, Last) Robert Michael Weeden				18. Mother's Name (First, Middle, Maiden Surname) Karen Preisinger			
19a. Informant's Name/Relationship (Type, Print) Ms. Karen Weeden mother				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9302 Millbrook Rd. Ellicott City, MD 21042			
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other Specify:		20b. Place of Disposition (Name of cemetery, crematory or other place) Bayview Crematory		Date 4/19/07	20c. Location - City or Town, State Baltimore, MD		
21. Signature of Funeral Service Licensee Nelby Michael Babbitt N01203		22. Name and Address of Facility Slack Funeral Home, P.A. 3871 Old Columbia Pike, MD 21043					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. a. Hanging Due to (or as a consequence of): b. _____ Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____							
<input type="checkbox"/> UNPENDED		<input checked="" type="checkbox"/> AMENDED #1, per ME, g869, 7/19/07 TT					
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Unknown				23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown							
23f. _____				24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other: Scene					
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) FOUND: Apr 13, 2007		28b. Time of Injury 1843 hrs	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred Subject hanged self	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Single Family		28f. Location (Street and Number or Rural Route Number, City or Town, State) 9302 Millbrook Rd., Ellicott City, Md.					
29a. Certifier 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
29b. Signature and title of certifier 				29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) April 14, 2007	
30. Name and address of person who completed cause of death (Item 23a) Jack Titus MD. Deputy Chief Medical Examiner 111 Penn Street, Baltimore, MD 21201							
31. Date filed (Month, Day, Year) APR 17 2007		32. Registrar's Signature 					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 12195

1- For State Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) MARTHA E. M. YOUNG						2. Date of Death Month 04 Day 11 Year 2007	3. Time of Death 2:12pm					
	4a. Facility Name (If not institution, give street and number) Washington Adventist Hospital			4b. City, Town, or Location of Death Takoma Park			4c. County of Death Montgomery						
Funeral Director	5. Social Security Number 579-66-1979		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 76 Yrs.	If Under 1 Year Months Days Hours Min.	8. Date of Birth (Month, Day, Year) 12-28-1930		9. Birthplace (State or Foreign Country) Georgia					
	Usual Residence of Decedent		10a. State DC 10b. County			10c. City, Town or Location Washington			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				
To Be Completed by Funeral Director	10e. Street and Number 23 Michigan Avenue			10f. Zip Code 20002-1011			10g. Citizen of What Country? USA						
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Black Specify:					
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Licensed Practical Nurse		16b. Kind of Business/Industry Private								
	17. Father's Name (First, Middle, Last) Frank Mathis, Sr.				18. Mother's Name (First, Middle, Maiden Surname) Callie Francis Benning								
	19a. Informant's Name/Relationship (Type, Print) Manvell Lessane Nephew			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 641 Girard Street NE Washington, DC 20017									
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Riverdale Park Crematory			Date 4/18/07	20c. Location - City or Town, State Riverdale, MD					
	21. Signature of Funeral Service Licensed				22. Name and Address of Facility Bianchi 814 Upshur St NW, Wash, DC 20011								
Physician /Medical Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <i>respiratory Failure</i>								Approximate Interval Between Onset and Death				
	b. Due to (or as a consequence of): <i>Hypoxia</i>												
	c. Due to (or as a consequence of): <i>Urinary tract infection</i>												
	d. Due to (or as a consequence of): <i>Sepsis</i>												
Medical Certification: To Be Completed by Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome pf pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____						23d. Date of delivery Month Day Year				
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>atrial fibrillation</i> <i>lactic acidosis</i>								23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown				
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred			24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
			28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)					28f. Location (Street and Number or Rural Route Number, City or Town, State)					
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.												
	29b. Signature and title of certifier <i>Van Mai, MD</i>		29c. License number D64561			29d. Date signed (Month, Day, Year) 4/13/07							
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Van Mai 7600 Carroll Avenue Takoma Park, MD 20912												
State Registrar	31. Date filed (Month, Day, Year) APR 17 2007		32. Registrar's Signature <i>Sean B. Spaul</i>										

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division or Vital Records, P.O. Box 68760, MD

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Amend #20b, per Ph G866, 4/17/07 TT
Registrar Amend #4a Per Phy G867 5/07/07 Certificate of Death

Reg. No. 2007 12195

Physician /Medical Examiner		Thomas Xavier Yorkshire							
Funeral Director		ST. Agnes Hospital Maryland General Hospital			4b. City, Town, or Location of Death Baltimore		4c. County of Death		
To Be Completed by Funeral Director		5. Social Security Number 217-32-4158	6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) 72 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	2. Date of Death Month Day Year APR 11 2007	3. Time of Death AM 835A ^M	
		Usual Residence of Decedent MD			10a. State MD			10b. County 10c. City, Town or Location Baltimore	10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No
		10e. Street and Number 712 North Gilmor Street			10f. Zip Code 21217		10g. Citizen of What Country? USA		
		11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify African American	
		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Clergy		16b. Kind of Business/Industry church			
		17. Father's Name (First, Middle, Last) Booker T. Everett			18. Mother's Name (First, Middle, Maiden Surname) Hazel Marie Yorkshire				
Physician /Medical Examiner		19a. Informant's Name/Relationship (Type, Print) John S. Yorkshire / Uncle			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1700 Edmondson Avenue Apt. 411; Baltimore, MD 21223				
		20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) Arlington National Cem.			20b. Place of Disposition (Name of cemetery, crematory or other place) Arlington National Cem.		Date 4/26/2007 04/23/2007	20c. Location - City or Town, State Arlington, Virginia	
		21. Signature of Funeral Service Licensee ▶ <i>Janet Jones</i>			22. Name and Address of Facility Wylie Funeral Home, P.A. 638 North Gilmor Street; Baltimore, Maryland 21217				
		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)			23b. Due to (or as a consequence of): <i>Acute Myocardial Infarction</i> Due to (or as a consequence of): <i>Coronary Artery Disease</i>			Approximate Interval Between Onset and Death Minutes.	
		23c. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last			23d. Due to (or as a consequence of): <i>Systemic Hypertension</i>			4 Years	
		23e. IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown			23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 4 <input type="checkbox"/> Pregnant at time of death 9 <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year	
		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Ischemic Cerebro Vascular Accident</i> <i>Systemic Hypertension</i>			23e. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown				
		25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				
		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide			28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred
					28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
		29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.			29b. Signature and title of Certifier <i>Isbeth N. Llovet</i>			29c. License number P20556	29d. Date signed (Month, Day, Year) APR 11 2007 21229
		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Isbeth N. Llovet 900 S Caton AVE, Baltimore, MD			31. Date filed (Month, Day, Year) APR 17 2007			32. Registrar's Signature <i>Janet Jones</i>	

ORIGINAL

THOMAS X. YORKSHIRE
Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 2 should be detached for use as the burial-transit

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 12197

Physician/ Medical Examiner		1. For State Registrar								
		1. Decedent's Name (First, Middle, Last) HENRY T. ZUREK						2. Date of Death Month April 11, 2007 Day Year	3. Time of Death 1537 hrs	
Funeral Director		4a. Facility Name (if not institution, give street and number) Howard County General Hospital			4b. City, Town, or Location of Death Columbia			4c. County of Death Howard		
		5. Social Security Number 214-48-1810	6. Sex 1 X M 2 F	7. Age (In yrs. last birthday) 58 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (MM/DD/YYYY) MAY 27, 1948	9. Birthplace (State or Foreign Country) MARYLAND		
To Be Completed by Funeral Director		Usual Residence of Decedent: 10a. State MARYLAND 10b. County ANNE ARUNDEL 10c. City, Town or Location GLEN BURNIE						10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 X No		
		10e. Street and Number 4 LENNON CT.			10f. Zip Code 21061			10g. Citizen of What Country? UNITED STATES		
To Be Completed by Physician/Medical Examiner		11. Marital Status 1 <input type="checkbox"/> Never Married 2 X Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 X No		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 X No specify: specify: WHITE			14. Race - American Indian, Black, White, etc. WHITE		
		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) SERVICE MANAGER			16b. Kind of Business/Industry BUILDING		
Physician /Medical Examiner		17. Father's Name (First, Middle, Last) WILLIAM STANLEY ZUREK				18. Mother's Name (First, Middle, Maiden Surname) AGNES KULINSKI				
		19a. Informant's Name/Relationship (Type, Print) E. LYNN ZUREK / DAUGHTER Wife			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4 LENNON CT., GLEN BURNIE, MARYLAND 21061					
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit		20a. Method of Disposition 1 X Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other Specify:	20b. Place of Disposition (Name of cemetery, crematory or other place) CEDAR HILL CEMETERY			Date APRIL 16, 2007	20c. Location - City or Town, State BROOKLYN PK., MARYLAND			
		21. Signature of Funeral Service Licensee [Signature]			22. Name and Address of Facility KIRKLEY-RUDDICK FUNERAL HOME, P.A. 421 CRAIN HWY., S.E., GLEN BURNIE, MD 21061					
Medical Certification: To Be Completed by Physician/Medical Examiner		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Cardiac arrhythmia due to hypertensive atherosclerotic cardiovascular disease Due to (or as a consequence of): b. _____ c. _____ d. _____ X <input type="checkbox"/> UNPENDED <input type="checkbox"/> AMENDED #23a, PII, 27, per ME, g866, 4/19/07 TT								
		Approximate Interval Between Onset and Death								
Medical Certification: To Be Completed by Physician/Medical Examiner		23b. Was decedent pregnant in the past 12 months? IF FEMALE: 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of 5 <input type="checkbox"/> Other (Specify) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown g <input type="checkbox"/> Unknown								
		23d. Date of delivery Month Day Year								
Medical Certification: To Be Completed by Physician/Medical Examiner		23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown								
		24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> N 24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No								
Medical Certification: To Be Completed by Physician/Medical Examiner		25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No								
		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other:								
Medical Certification: To Be Completed by Physician/Medical Examiner		27. Manner of Death 1 X Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide								
		28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)								
Medical Certification: To Be Completed by Physician/Medical Examiner		29a. Certifier 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
		29b. Signature and title of certifier Ana Rubid MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201								
State Registrar		29c. License number O.C.M.E. 29d. Date signed (Month, Day, Year) April 13, 2007								
		30. Name and address of person who completed cause of death (Item 23a) Ana Rubid MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201								
State Registrar		31. Date filed (Month, Day, Year) APR 17 2007 32. Registrar's Signature [Signature] ORIGINAL								

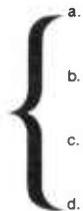
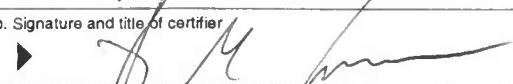
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 12198

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Robert Scott Alexander							2. Date of Death 4/14/07 Day Year	3. Time of Death 8:39AM		
	4a. Facility Name (If not institution, give street and number) 14823 Railroad st			4b. City, Town, or Location of Death Midland			4c. County of Death Allegany				
Funeral Director	5. Social Security Number 218-64-9332	6. Sex 1 X M 2 □ F	7. Age (In yrs. last birthday) 53 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	Hours	Min.	8. Date of Birth July 22, 1939	9. Birthplace (State or Foreign Country) Maryland		
To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State Maryland 10b. County Allegany 10c. City, Town or Location Midland 10d. Inside City Limits 1 X Yes 2 □ No										
	10e. Street and Number 14823 Railroad Street			10f. Zip Code 21542			10g. Citizen of What Country? U.S.A.				
	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 X Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 X No If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No) 1 □ Yes 2 X No Specify:			14. Race - American Indian, Black, White, etc. Specify: White			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 2 Customer Service Representative			16b. Kind of Business/Industry Telemarketing				
	17. Father's Name (First, Middle, Last) Robert Scott Alexander, Sr.				18. Mother's Name (First, Middle, Maiden Surname) Norma Shearer						
	19a. Informant's Name/Relationship (Type, Print) Craig Alexander - Brother				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14831 Back Street, Midland, Maryland, 21542						
	20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Frostburg Memorial Park			Date April 07, 2007	20c. Location - City or Town, State Frostburg, Maryland			
Physician /Medical Examiner	21. Signature of Funeral Service Licensee 			22. Name and Address of Funeral Home Eichhorn-McKenzie Funeral Home P.A. 8 East Main Street, Lonaconing, Maryland 21539							
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) ASCVD								Approximate Interval Between Onset and Death yrs		
	a. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):										
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (Specify) 9 □ Unknown					23d. Date of delivery Month Day Year			
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23e. Did tobacco use contribute to the cause of death? 1 □ Yes 2 □ No 3 X Probably 4 □ Unknown		
									24a. Was an autopsy performed? 1 □ Yes 2 X No		24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No
	25. Was case referred to medical examiner? 1 X Yes 2 □ No		26. Place of Death (Check only one) Hospital: 1 □ Inpatient 2 □ ER/Outpatient 3 □ DOA Other: 4 □ Nursing Home 5 X Residence 6 □ Other (Specify)								
	27. Manner of Death 1 X Natural 2 □ Accident 3 □ Suicide 4 □ Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury	28c. Injury at Work? M	28d. Describe how injury occurred				
	5 □ Pending investigation 6 □ Could not be determined					1 □ Yes 2 □ No					
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)						
	29a. Certifier (Check only one) 1 □ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 X Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							29d. Date signed (Month, Day, Year) April 4 2007			
	29b. Signature and title of certifier 		29c. License number D09157								
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Paul Snow M.D. dpty Med ex 124 W 3rd St Cumberland MD 21502										
	31. Date filed (Month, Day, Year) APR - 9 2007		32. Registrar's Signature 								

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

07-02629

Naomi Elizabeth Arliss

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2007 12199

**Physician/
Medical Examiner**1- For State
Registrar

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death 1550 hrs
Naomi Elizabeth Arliss	April 6, 2007	

**Funeral
Director**

4a. Facility Name (if not institution, give street and number) 6403 Falcon Avenue	4b. City, Town, or Location of Death Seaford	4c. County of Death Dorchester
--	---	-----------------------------------

5. Social Security Number 216-70-5659	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 51 Yrs.	If Under 1 Year Months Days Hours Min.	8. Date of Birth (MM/DD/YYYY) Mar. 16, 1956	9. Birthplace (State or Foreign Country) MD
--	--	---	---	--	--

Usual Residence of Decedent 10a. State MD 10b. County Dorchester 10c. City, Town or Location Seaford					10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
--	--	--	--	--	--

10e. Street and Number 6403 Falcon Avenue	10f. Zip Code 19973	10g. Citizen of What Country? USA
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11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married	12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No specify: white	14. Race - American Indian, Black, White, etc. Specify: white
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15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+)	16b. Kind of Business/Industry homemaker
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17. Father's Name (First, Middle, Last) George W. McGrath	18. Mother's Name (First, Middle, Maiden Surname) Marie Trice
--	--

19a. Informant's Name/Relationship (Type, Print) Joseph R. Arliss husband	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6403 Falcon Ave., Seaford, DE 19973
--	--

20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State	20b. Place of Disposition (Name of cemetery, crematory or other place) Salisbury Crematory	Date 4/9/07	20c. Location - City or Town, State Salisbury, MD
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21. Signature of Funeral Service Licensee B. K. B.	22. Name and Address of Facility Thomas Funeral Home P.A. 700 Locust St., Cambridge, MD 21613
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Baltimore, MD 21215-0036

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Permit: Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

**Physician/
Medical
Examiner**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit

Division of Vital Records, P.O. Box 68760,

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)	a. <u>Complications of morbid obesity</u> Due to (or as a consequence of):	Approximate Interval Between Onset and Death
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Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Causes (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):
---	--

c. Due to (or as a consequence of):
--

d. UNPENDED <input checked="" type="checkbox"/> AMENDED #23a,27,perME, g868, 6/11/07 TT
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IF FEMALE:	23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown	23d. Date of delivery Month Day Year
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23b. Was decedent pregnant in the past 12 months?	1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown	23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown
---	--	--

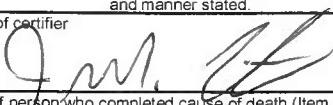
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23f. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No
--	--

25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other: Scene
---	--

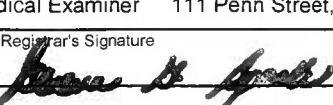
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Homicide 4 <input type="checkbox"/> Homicide	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred
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	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)
--	---	--

29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
--

29b. Signature and title of certifier 	29c. License number O.C.M.E.	29d. Date signed (Month, Day, Year) April 7, 2007
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30. Name and address of person who completed cause of death (Item 23a) Jack Titus MD. Deputy Chief Medical Examiner 111 Penn Street, Baltimore, MD 21201

31. Date filed (Month, Day, Year) APR 10 2007	32. Registrar's Signature 
--	--

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 12200

1 - For
State
RegistrarPhysician
/Medical
ExaminerFuneral
Director

To Be Completed by Funeral Director

MAE L. ALLEN
Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) <i>Leona Mae Allen</i>			2. Date of Death Month MARCH Day 17 Year 2007			3. Time of Death 1745 M
4a. Facility Name (If not institution, give street and number) <i>Memorial Hospital@ EASTON</i>			4b. City, Town, or Location of Death EASTON			4c. County of Death Talbot
5. Social Security Number 218-18-6310	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 83 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Hours	8. Date of Birth (Month, Day, Year) October 7, 1923	9. Birthplace (State or Foreign Country) Maryland
Usual Residence of Decedent 10a. State Maryland 10b. County Caroline			10c. City, Town or Location Denton			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
10e. Street and Number 9393 Reed Road			10f. Zip Code 21629			10g. Citizen of What Country? United States of America
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: Caucasian
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11 HS Grad		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Line worker		16b. Kind of Business/Industry Food Processing		
17. Father's Name (First, Middle, Last) <i>William Sebastian George</i>			18. Mother's Name (First, Middle, Maiden Surname) <i>Anna Leona Foxwell</i>			
19a. Informant's Name/Relationship (Type, Print) <i>Kimberley A. Blades Daughter</i>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>9393 Reed Road, Denton, Maryland 21629</i>			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Greenmount Cemetery</i>			Date 3/20/2007
21. Signature of Funeral Service Licensee <i>Randolph P. Rose</i>			22. Name and Address of Facility <i>Moore Funeral Home, P.A. 92 South Second Street, Denton, Maryland 21629</i>			20c. Location - City or Town, State <i>Hillsboro, Maryland</i>
23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)			23b. Due to (or as a consequence of): <i>VENTRICULAR TACHYCARDIA</i>			Approximate Interval Between Onset and Death <i>MINUTES</i>
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last			23c. Due to (or as a consequence of):			
			23d. Due to (or as a consequence of):			
			23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown			23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify)			23d. Date of delivery Month Day Year
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>PNEUMONIA</i>			23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide			28a. Date of Injury (Month, Day, Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred
			28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.			29c. License number D 31376			29d. Date signed (Month, Day, Year) 3-20-07
29b. Signature and title of certifier <i>James Sides MD</i>			30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>James Sides 920 Market St Denton MD</i>			
31. Date filed (Month, Day, Year) MAR 20 2007			32. Registrar's Signature <i>Patricia A. Smith</i>			

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

23a. State of Maryland / Department of Health and Mental Hygiene
Amend Item 23 per me, g866, 04/26/07 dhb Certificate of Death 2007 12201
1- For State Registrar Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) HAROLD ALTFATHER				2. Date of Death Month Day Year March 16 2007	3. Time of Death 9:55 A M	
	4a. Facility Name (If not institution, give street and number) North Arundel Health & Rehabilitation		4b. City, Town, or Location of Death Glen Burnie		4c. County of Death Anne Arundel		
Funeral Director	5. Social Security Number 273-18-5704	6. Sex M	7. Age (In yrs. last birthday) 86 Yrs.	If Under 1 Year Months Days Hours Min. 0 0 0 0	B. Date of Birth (Month, Day, Year) November 11, 1920	9. Birthplace (State or Foreign Country) Maryland	
	Usual Residence of Decedent 10a. State Maryland		10b. County Caroline		10c. City, Town or Location Denton		10d. Inside City Limits <input type="checkbox"/> Yes <input type="checkbox"/> No
To Be Completed by Funeral Director	10e. Street and Number 517 Market Street		10f. Zip Code 21629		10g. Citizen of What Country? United States of America		
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: 1945-1948		13. Was Decedent of Hispanic Origin? (Specify Yes or No) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: Caucasian		14. Race - American Indian, Black, White, etc. Caucasian
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Salesman		16b. Kind of Business/Industry Automobiles		
	17. Father's Name (First, Middle, Last) John Walker Altfather		18. Mother's Name (First, Middle, Maiden Surname) Malissa Jane Will				
	19a. Informant's Name/Relationship (Type, Print) John Altfather Son		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8096 New Cut Road, Severn, Maryland 21144		Date 3/17/2007	20c. Location - City or Town, State Dover, Delaware	
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Capitol Crematory		20c. Name and Address of Facility Moore Funeral Home, P.A.		
	21. Signature of Funeral Service Licensee Ronald J. Moore		22. Name and Address of Facility 12 South Second Street, Denton, Maryland 21629				
Physician /Medical Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Metastatic liver ca, bones, Skin Approximate Interval Between Onset and Death 11 months						
	23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown						
	23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown						
	23d. Date of delivery Month Day Year						
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit	23e. Did tobacco use contribute to the cause of death? No						
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No						
	24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No						
Medical Certification: To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No						
	26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined						
	28a. Date of Injury (Month, Day, Year) 28b. Time of Injury M 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No						
	28d. Describe how injury occurred						
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) At home						
	28f. Location (Street and Number or Rural Route Number, City or Town, State) GLEN BURNIE, MD 21611						
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.						
	29b. Signature and title of Certifier Rita Chandravall MD Attending Physician						
	29c. License number D 029873						
	29d. Date signed (Month, Day, Year) 03/16/2007						
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RITA CHANDRAVALL MD 313 HOSPITAL DR. GLEN BURNIE, MD 21611						
State Registrar	31. Date filed (Month, Day, Year) APR 1 2007						
	32. Registrar's Signature [Signature]						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2007 12202

Reg. No.

1- For
State
Registrar

Physician
/Medical
Examiner

Funeral
Director

To Be Completed by Funeral Director

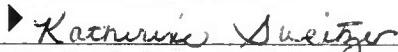
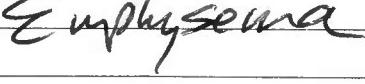
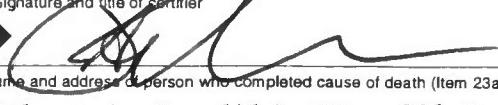
Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important! If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last)		Mildred A. Albright				2. Date of Death Month 03 Day 29 Year 2007	3. Time of Death 3:20a M
4a. Facility Name (If not institution, give street and number)		Garrett County Memorial Hospital				4c. County of Death Garrett	
5. Social Security Number 235-50-2980		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 86 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) 06/21/1920	9. Birthplace (State or Foreign Country) Albright, WV
Usual Residence of Decedent 10a. State WV 10b. County Preston 10c. City, Town or Location Terra Alta 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No							
10e. Street and Number 200 Aurora Pike				10f. Zip Code 26764			10g. Citizen of What Country? USA
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Nurses Aide			16b. Kind of Business/Industry Medical
17. Father's Name (First, Middle, Last) Harvey G. Conner				18. Mother's Name (First, Middle, Maiden Surname) Edna Walls Conner			
19a. Informant's Name/Relationship (Type, Print) Phyllis Thorn				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 200 Aurora Pike, Terra Alta, WV 26764			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Mt. Morriah Cemetery		Date 03/31/07		20c. Location - City or Town, State Albright, WV	
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility 201 E. Main St. Browning Funeral Home, Kingwood, WV 26537			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Pneumonia							
Approximate Interval Between Onset and Death 1wk							
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							
a. Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.							
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown <input type="checkbox"/> Other (specify)		23d. Date of delivery Month Day Year			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 							
23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown							
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
29b. Signature and title of certifier 				29c. License number D23979			29d. Date signed (Month, Day, Year) 3.29.7.
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Robert A. Goralski, MD., 311 North Fourth Street, Oakland, MD 21550							
31. Date filed (Month, Day, Year) APR - 2 2007		32. Registrar's Signature 					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 12203

1-For State Registrar

Physician/
Medical Examiner

1. Decedent's Name (First, Middle, Last) Matthew Edward Bryant		2. Date of Death Month Day Year April 7, 2007	3. Time of Death 2045 hrs
4a. Facility Name (if not institution, give street and number) 1634 Hughes Shop Rd		4b. City, Town, or Location of Death Westminster	4c. County of Death Carroll
5. Social Security Number 213-94-4974	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 36 Yrs.	If Under 1 Year Months Days Hours Min. Feb 15 1971
8. Date of Birth (MM/DD/YYYY) Feb 15 1971		9. Birthplace (State or Foreign Country) MD	
10a. State MD		10b. County Carroll	
10c. City, Town or Location Westminster		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number 1634 Hughes Shop Road		10f. Zip Code 21158	10g. Citizen of What Country? USA
11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: Elementary/Secondary (0-12) 12 College (1-4 or 5+)	13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No specify: Outside Plant Technician Billing Specialist	14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired). Outside Plant Technician Billing Specialist	
17. Father's Name (First, Middle, Last) Arnold E. Bryant		18. Mother's Name (First, Middle, Maiden Surname) Dorothy Petry	
19a. Informant's Name/Relationship (Type, Print) Dorothy Bryant/Mother		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1634 Hughes Shop Road Westminster, MD 21158	
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other Specify: <i>Paul Dohm</i>	20b. Place of Disposition (Name of cemetery, crematory or other place) Meadow Branch Cemetery	Date 04/12/2007	20c. Location - City or Town, State Westminster, MD
21. Signature of Funeral Service Licensee		22. Name and Address of Facility Pritts Funeral Home and Chapel, P.A. 412 Washington Rd Westminster, MD 21157	
23a. Part I Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Cardiac arrhythmia Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. <input checked="" type="checkbox"/> UNPENDED <input type="checkbox"/> AMENDED #2a,27, per ME, G867, 5/16/07 TT			
23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) g. <input type="checkbox"/> Unknown	23d. Date of delivery Month Day Year
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.			
		23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown	
		24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other: Scene	
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred
		28e. Place of Injury - At home, farm, street, factory, office building, etc.	28f. Location (Street and Number or Rural Route Number, City or Town, State)
29a. Certifier 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29c. License number O.C.M.E.	
29b. Signature and title of certifier <i>J.W. Titus</i>		29d. Date signed (Month, Day, Year) April 8, 2007	
30. Name and address of person who completed cause of death (Item 23a) Jack Titus MD. Deputy Chief Medical Examiner 111 Penn Street, Baltimore, MD 21201		31. Date filed (Month, Day, Year) APR 11 2007	
32. Registrar's Signature <i>James B. Jones</i>		33. Original	

Division of Vital Records, P.O. Box 68760,
To Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial - transit

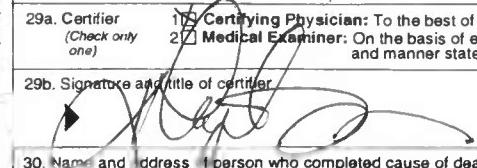
Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Ammended 16A per F.H. Carroll Co. WSH Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 17, 18 per fh g876 2-6-08 v1											
State of Maryland, Department of Health and Mental Hygiene											
2007 12204											
1- For State Registrar amend item 17 per fh g876 2-6-08 v1 Certificate of Death											
Reg. No.											
Physician /Medical Examiner											
<p>1. Decedent's Name (First, Middle, Last) Robert Emmett Beams</p> <p>4a. Facility Name (If not institution, give street and number) Ctr University of Maryland Medical 4b. City, Town, or Location of Death Baltimore 4c. County of Death</p> <p>5. Social Security Number 322-20-0285 6. Sex 1 M 2 F 7. Age (In yrs. last birthday) 78 Yrs. 8. Date of Birth (Month, Day, Year) Dec 27 1928 9. Birthplace (State or Foreign Country) MI</p> <p>10a. State MD 10b. County Carroll 10c. City, Town or Location Taneytown 10d. Inside City Limits 1 Yes 2 No</p> <p>10e. Street and Number 2932 Kump Station Road 10f. Zip Code 21787 10g. Citizen of What Country? USA</p> <p>11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No) 1 Yes 2 No Specify: 14. Race - American Indian, Black, White, etc. White</p> <p>15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Special Agent 16b. Kind of Business/Industry FBI</p> <p>College (1-4 or 5+) 5+ Special Agent</p> <p>17. Father's Name (First, Middle, Last) Harry C. Beams 18. Mother's Name (First, Middle, Maiden Surname) Jessie M. O'Connor</p> <p>Harry E. Beams, Sr. Jessie O'Connor</p> <p>19a. Informant's Name/Relationship (Type, Print) Barbara Beams/wife 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2932 Kump Station Road Taneytown, MD 21787</p> <p>20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) Carroll Cremation, Inc 20c. Location - City or Town, State Hampstead, MD</p> <p>21. Signature of Funeral Service Licensee </p> <p>22. Name and Address of Facility Pritt's Funeral Home and Chapel, P.A. 412 Washington Rd Westminster, MD 21157</p> <p>23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.</p> <p>Immediate Cause (Final disease or condition resulting in death) a. BILATERAL SUBDURAL HEMATOMA / INTRAVENTRICULAR HEMORRHAGE / 2 HOURS</p> <p>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</p> <p>b. Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. Due to (or as a consequence of):</p> <p>Approximate Interval Between Onset and Death 2 hours</p> <p>IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 9 Unknown</p> <p>23d. Date of delivery Month Day Year</p> <p>Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.</p> <p>23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown</p> <p>24a. Was an autopsy performed? 1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No</p> <p>25. Was case referred to medical examiner? 1 Yes 2 No 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)</p> <p>27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined 28a. Date of Injury (Month, Day, Year) 3/30/07 28b. Time of Injury 5:30 A.M. 28c. Injury at Work? 1 Yes 2 No 28d. Describe how injury occurred FALL</p> <p>28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Home 28f. Location (Street and Number or Rural Route Number, City or Town, State) 2932 Kump Station Taneytown, MD 21787</p> <p>29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.</p> <p>29b. Signature and title of certifier  29c. License number D63970 29d. Date signed (Month, Day, Year) APR 3 2007</p> <p>30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. KATHLENE LANGSTON 22 S GREEN ST. ACTO, MD 21201</p> <p>31. Date filed (Month, Day, Year) APR 03 2007 32. Registrar's Signature </p>											

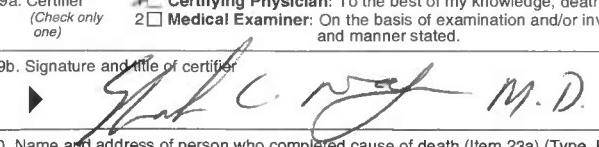
**Amend 23a Part I per Physician 04/02/2007 Carroll County, wj1
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 12205

1- For State Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Gary Alexander Bliss					2. Date of Death Month 3 Day 28 Year 2007	3. Time of Death 3:51 P.M.
	4a. Facility Name (If not institution, give street and number) Dove House		4b. City, Town, or Location of Death Westminster		4c. County of Death Carroll		
Funeral Director	5. Social Security Number 214-84-8859	6. Sex 1 M 2 F	7. Age (In yrs. last birthday) 43 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days Hours Min.	8. Date of Birth (Month, Day, Year) 10/13/1963	9. Birthplace (State or Foreign Country) Maryland
	Usual Residence of Decedent 10a. State MD		10b. County Baltimore	10c. City, Town or Location Upperco			10d. Inside City Limits 1 Yes 2 No
To Be Completed by Funeral Director	10e. Street and Number 15119 Eastview Drive			10f. Zip Code 21155		10g. Citizen of What Country? United States	
	11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Car Specialist			16b. Kind of Business/Industry Automobiles	
17. Father's Name (First, Middle, Last) Robert A. Bliss				18. Mother's Name (First, Middle, Maiden Surname) Herta Koller			
19a. Informant's Name/Relationship (Type. Print) Herta Davis - Mother				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15119 Eastview Drive, Upperco, Maryland 21155			
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) 			20b. Place of Disposition (Name of cemetery, crematory or other place) Carroll Cremation		Date 3/30/2007	20c. Location - City or Town, State Hampstead, Maryland	
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Eline Funeral Home, 934 South Main Street, Hampstead, Maryland 21074			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							
<p>a. LIVER FAILURE Due to (or as a consequence of): Cirrhosis Approximate Interval Between Onset and Death 1 WEEK</p> <p>b. Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. Due to (or as a consequence of):</p>							
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome pf pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) Unknown				23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown							
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No					
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) DOVE HOUSE					
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred	
28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
29b. Signature and title of certifier 		29c. License number 0059552		29d. Date signed (Month, Day, Year) 3/29/2007			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GOURISHANKAR C. MAGANIA 700A POOLE RD WESTMINSTER MD 21157							
31. Date filed (Month, Day, Year) APR 02 2007		32. Registrar's Signature 					

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

1. WJ
I + 1

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or items 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

State Registrar

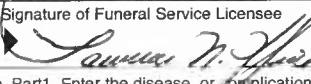
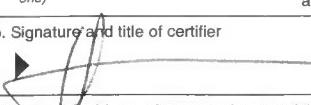
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 12206

1 - For
State
Registrar

Physician / Medical Examiner	1. Decedent's Name (First, Middle, Last) SOLEDAD IGLESIAS BARONE					2. Date of Death Month March	Day 21	Year 2007	3. Time of Death 4:30 p^M	
	4a. Facility Name (If not institution, give street and number) Washington Adventist Hospital					4b. City, Town, or Location of Death Tacoma Park			4c. County of Death Montgomery	
Funeral Director	5. Social Security Number 051-28-0167	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 83 Yrs.	If Under 1 Year Months 83	If Under 24 Hrs. Hours 0	Min. 0	8. Date of Birth (Month, Day, Year) August 21, 1923	9. Birthplace (State or Foreign Country) Philippines		
	Usual Residence of Decedent 10a. State Maryland					10b. County Montgomery			10c. City, Town or Location Silver Spring	
10e. Street and Number 8103 Eastern Ave. #313 B					10f. Zip Code 20910			10g. Citizen of What Country? U.S.A.		
To Be Completed by Funeral Director	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 5+		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker			14. Race - American Indian, Black, White, etc. Specify: Filipino		
17. Father's Name (First, Middle, Last) Florencio Iglesias					18. Mother's Name (First, Middle, Maiden Surname) Mercedes Urquiola					
19a. Informant's Name/Relationship (Type, Print) Therese Gouaux (Sister-in-law)					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8201 16th Street #1110, Silver Spring, Maryland 20910					
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) Cremation Center					20b. Place of Disposition (Name of cemetery, crematory or other place) Cremation Center		Date 04/03/07	20c. Location - City or Town, State Chantilly, Virginia		
21. Signature of Funeral Service Licensee 					22. Name and Address of Facility Murphy Falls Church Funeral Home 1102 W. Broad St., Falls Church, Va. 22046					
Physician / Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)					Approximate Interval Between Onset and Death Atherosclerotic Cardiac Disease				
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last									
a. Due to (or as a consequence of):										
b. Due to (or as a consequence of):										
c. Due to (or as a consequence of):										
d. Due to (or as a consequence of):										
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown <input type="checkbox"/> Other (specify) _____					23d. Date of delivery Month Day Year			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input checked="" type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred			
		28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
29b. Signature and title of certifier 		29c. License number 35826					29d. Date signed (Month, Day, Year) 3/21/07			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Horacio Schapiro M.D.							7600 Carroll Ave. Takoma Park, MD 20901			
State Registrar	31. Date filed (Month, Day, Year) APR 03 2007		32. Registrar's Signature 							

Baltimore, Maryland 21215-0036

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2007 12207

**1- For
State
Registrar**

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Ali Ahmed Bader					2. Date of Death Month March Day 30 , Year 2007	3. Time of Death 2:30A. M		
	4a. Facility Name (If not institution, give street and number) Shady Grove Adventist Hospital			4b. City, Town, or Location of Death Rockville		4c. County of Death Montgomery			
Funeral Director	5. Social Security Number 256-59-2301	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 81 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Hours	8. Date of Birth (Month, Day, Year) Sept. 7, 1925	9. Birthplace (State or Foreign Country) India		
	Usual Residence of Decedent			10a. State Maryland 10b. County Montgomery 10c. City, Town or Location Rockville			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
	10e. Street and Number 10210 Silver Bell Terrace			10f. Zip Code 20850		10g. Citizen of What Country? India			
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Asian			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Self Employed		16b. Kind of Business/Industry Retail				
	17. Father's Name (First, Middle, Last) Ali			18. Mother's Name (First, Middle, Maiden Surname) Mohammed Hasan Banu					
	19a. Informant's Name/Relationship (Type, Print) Fazal U. Bader -wife			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10210 Silver Bell Terrace Rockville, Maryland 20850					
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) MD National Mem. Park		Date 3/30/2007	20c. Location - City or Town, State Laurel, Maryland		
	21. Signature of Funeral Service Licensee Donald V. Borgwardt			22. Name and Address of Facility Donald V. Borgwardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Maryland 20705					
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Respiratory Failure Due to (or as a consequence of): Aspiration Pneumonia								
	Approximate Interval Between Onset and Death 2 weeks								
	Sequentially list conditions, if any, leading to the immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Stroke Due to (or as a consequence of): years								
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown								
	23c. If yes, outcome pf pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown <input type="checkbox"/> Other (specify) _____								
	23d. Date of delivery Month Day Year								
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								
	23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown								
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No								
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
	26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide								
	28a. Date of Injury (Month, Day, Year) 28b. Time of Injury M 28c. Injury at Work? 1□ Yes 2□ No 28d. Describe how injury occurred								
	28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)								
	28f. Location (Street and Number or Rural Route Number, City or Town, State)								
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
	29b. Signature and title of certifier Jude Rajind Alexander, M.D.								
	29c. License number D58681								
	29d. Date signed (Month, Day, Year) March 30, 2007								
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jude Rajind Alexander, M.D. 9901 Medical Center Drive Rockville, Maryland 20850								
	31. Date filed (Month, Day, Year) APR 03 2007								
	32. Registrar's Signature Leanne B. Bader								

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit once.

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Bader, Ali Baltimore, Maryland 21215-0036

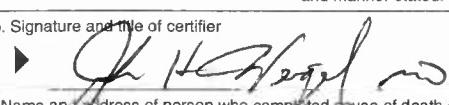
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 12208

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Edward Michael Bassett, Jr.							2. Date of Death Month Day Year April 2 2007	3. Time of Death 7:49 A M
	4a. Facility Name (If not institution, give street and number) Calvert Memorial Hospital			4b. City, Town, or Location of Death Prince Frederick			4c. County of Death Calvert		
Funeral Director	5. Social Security Number 217-44-9581	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 61 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) April 7 1945	9. Birthplace (State or Foreign Country) Washington, DC		
To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State MD 10b. County Calvert 10c. City, Town or Location Chesapeake Beach								10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
	10e. Street and Number 8528 F Street			10f. Zip Code 20732			10g. Citizen of What Country? United States		
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: 1945			13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: white			14. Race - American Indian, Black, White, etc. Specify: white	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Surveyor party chief			16b. Kind of Business/Industry Sanitary Utility		
	17. Father's Name (First, Middle, Last) Edward Michael Bassett, Sr.				18. Mother's Name (First, Middle, Maiden Surname) Ethel Mae Suit				
	19a. Informant's Name/Relationship (Type, Print) Betty Ann Bassett, Spouse				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8528 F St. Chesapeake Beach, MD 20732				
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) Lakemont Mem. Grdns.			20b. Place of Disposition (Name of cemetery, crematory or other place)		Date 04-06-2007	20c. Location - City or Town, State Davidsonville, MD		
Physician /Medical Examiner	21. Signature of Funeral Service Licensee 			22. Name and Address of Facility Rausch Funeral Home, PA Owings, MD 20736					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) STATUS ASTHMATICUS								Approximate Interval Between Onset and Death 1-2 HOURS
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last ASTHMA								
	23b. If female: 23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown								23d. Date of delivery Month Day Year
Medical Certification: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CHRONIC RENAL FAILURE DIABETES MELLITUS								23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
	25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA			Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide			28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work? M <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred		
	28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)					
	29a. Certifier (Check only one) <input type="checkbox"/> Identifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.			29b. Signature and title of certifier 					
	29c. License number D26358			29d. Date signed (Month, Day, Year) APRIL 2, 2007					
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JOHN H. WEIGEL, M.D. - PRINCE FREDERICK, MD 20678			31. Date filed (Month, Day, Year) APR 03 2007					
	32. Registrar's Signature 								

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit slip.

Important: If Item 27 is marked other than "natural", or items 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 12209

1- For State Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) CHARLES William Ballard			2. Date of Death Month 03 Day 30 Year 1809 M	3. Time of Death			
	4a. Facility Name (If not institution, give street and number) Peninsula Regional Medical Center			4b. City, Town, or Location of Death Salisbury		4c. County of Death Wicomico		
Funeral Director	5. Social Security Number 215-26-4518	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 81 Yrs.	If Under 1 Year Months Days Hours Min.	8. Date of Birth (Month, Day, Year) 07-16-1925	9. Birthplace (State or Foreign Country) MD		
To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State MD 10b. County Somerset			10c. City, Town or Location Princess Anne			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
	10e. Street and Number 30767 Hampden Ave			10f. Zip Code 21853		10g. Citizen of What Country? U.S.A.		
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: 1945		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: Black		14. Race - American Indian, Black, White, etc. Specify: Black	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11th			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Maintenance			16b. Kind of Business/Industry University of Maryland Eastern Shore	
	17. Father's Name (First, Middle, Last) Earl R. Ballard Sr.			18. Mother's Name (First, Middle, Maiden Surname) Lena Adams				
	19a. Informant's Name/Relationship (Type, Print) Arnold Ballard - Brother			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 403 Princess Anne, MD 21853				
Physician /Medical Examiner	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) John Wesley Cemetery			20b. Place of Disposition (Name of cemetery, crematory or other place) John Wesley Cemetery		Date 4-5-07	20c. Location - City or Town, State Princess Anne, MD	
Medical Certification: To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee Anthony E. Ward Jr.			22. Name and Address of Facility Anthony E. Ward Funeral Home 30639 Hampden Ave. Princess Anne, MD 21853				
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)						Approximate Interval Between Onset and Death	
	a. Severe Sepsis Due to (or as a consequence of):							
	b. Atherosclerotic cardiovascular disease Due to (or as a consequence of):							
	c. _____ Due to (or as a consequence of):							
	d. _____ Due to (or as a consequence of):							
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome pf pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown <input type="checkbox"/> Other (specify) _____			23d. Date of delivery Month Day Year		
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.			23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown				
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			23f. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred	
			28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29c. License number D0063991		29d. Date signed (Month, Day, Year) 4/2/07			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Anupama Varadarajan 100 E. Carroll St. Salisbury MD 21801							
State Registrar	31. Date filed (Month, Day, Year) APR 03 2007		32. Registrar's Signature Stevens & Sons					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 12210

1- For State Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Ruth Dunlap Bracey					2. Date of Death Month April Day 1 Year 2007	3. Time of Death 5:30 AM
	4a. Facility Name (If not institution, give street and number) College View Nursing Home			4b. City, Town, or Location of Death Frederick		4c. County of Death Frederick	
Funeral Director	5. Social Security Number 001-36-4695	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 93 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days Hours Min.	8. Date of Birth (Month, Day, Year) May 19, 1913	9. Birthplace (State or Foreign Country) New Hampshire
To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State Maryland 10b. County Frederick 10c. City, Town or Location Frederick						10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
	10e. Street and Number 5860 Genesis Lane, #424			10f. Zip Code 21703		10g. Citizen of What Country? United States	
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 4		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Homemaker		16b. Kind of Business/Industry Own Home		
	17. Father's Name (First, Middle, Last) Fred Dunlap			18. Mother's Name (First, Middle, Maiden Surname) Abbie Shaw			
	19a. Informant's Name/Relationship (Type. Print) Janice Condrey / Daughter			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8613 Burnt Hickory Cir., Frederick, MD 21704			
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Resthaven Crematory		Date April 3, 2007	20c. Location - City or Town, State Frederick, Maryland	
	21. Signature of Funeral Service Licensee 			22. Name and Address of Facility Resthaven Funeral Services, Skkot Cody P.A. 9501 Catoctin Mtn. Hwy. Frederick, MD 21701			
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Dementia Approximate Interval Between Onset and Death >1 year						
	23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown						
	23c. If yes, outcome pf pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____						
	23d. Date of delivery Month Day Year						
Medical Certification: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						
	23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown						
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						
	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No						
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						
	26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide						
	28a. Date of Injury (Month, Day Year) M 28b. Time of Injury 1□ Yes 2□ No 28c. Injury at Work?						
	28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)						
	28f. Location (Street and Number or Rural Route Number, City or Town, State)						
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.						
	29b. Signature and title of certifier 						
	29c. License number DOO60417						
	29d. Date signed (Month, Day, Year) 4/3/07						
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hemen Shah, 650 Thomas Johnson Dr, Frederick MD 21702						
State Registrar	31. Date filed (Month, Day, Year) APR 04 2007	32. Registrar's Signature 					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

Physician /Medical Examiner		1. Decedent's Name (First, Middle, Last) Richard N. Bowe						2. Date of Death Month Day Year April 3 2007	3. Time of Death 10:05a M	
Funeral Director		4a. Facility Name (If not institution, give street and number) 901 Yacht Club Dr.			4b. City, Town, or Location of Death Berlin			4c. County of Death Worcester		
To Be Completed by Funeral Director		5. Social Security Number 156-24-1817		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 77 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) 7-17-1929	9. Birthplace (State or Foreign Country) NY	
		Usual Residence of Decedent		10a. State MD	10b. County Worcester	10c. City, Town or Location Berlin				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
		10e. Street and Number 901 Yacht Club Dr.					10f. Zip Code 21811	10g. Citizen of What Country? USA		
		11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: 1951 to 1952			13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: White			14. Race - American Indian, Black, White, etc.
		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 4			Management Consultant			16b. Kind of Business/Industry Consulting Firm
		17. Father's Name (First, Middle, Last) F. Nelson Bowe					18. Mother's Name (First, Middle, Maiden Surname) Alma E. Damm			
		19a. Informant's Name/Relationship (Type, Print) Alice S. Bowe (wife)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 901 Yacht Club Dr., Berlin, Md. 21811						
		20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) Cape Henlopen Crem.		20b. Place of Disposition (Name of cemetery, crematory or other place) Cape Henlopen Crem.			Date 4-5-2007	20c. Location - City or Town, State Frankford, DE		
21. Signature of Funeral Service Licensee Herm MacLeod		22. Name and Address of Facility The Burbage Funeral Home 108 William St., Berlin, Md. 21811								
Physician /Medical Examiner		<p>23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.</p> <p>Immediate Cause (Final disease or condition resulting in death)</p> <p>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</p> <p>a. Due to (or as a consequence of): Pancreatic Carcinoma</p> <p>b. Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. Due to (or as a consequence of):</p> <p>Approximate Interval Between Onset and Death 2 years</p>								
Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036		<p>23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown</p> <p>23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown</p> <p>23d. Date of delivery Month Day Year</p>								
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit		<p>23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown</p> <p>24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>								
Medical Certification: To Be Completed by Physician/Medical Examiner		<p>25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)</p> <p>27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide</p> <p>28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No 28d. Describe how injury occurred</p> <p>28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)</p> <p>28f. Location (Street and Number or Rural Route Number, City or Town, State)</p>								
		<p>29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.</p> <p>29b. Signature and title of certifier Mary S. DeShields</p> <p>29c. License number D417232</p> <p>29d. Date signed (Month, Day, Year) 4/04/2007</p>								
		<p>30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mary S. DeShields, M.D. 401 Purdy St., Easton, Md. 21601</p>								
State Registrar		<p>31. Date filed (Month, Day, Year) APR 04 2007</p> <p>32. Registrar's Signature Leanne B. Foster</p>								

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: if item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, **The Medical Examiner must be notified**.

Baltimore, Maryland 21215-0036

Permit: Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, **the Medical Examiner must be notified**.

Ques.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 12212

1- For State Register

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) ROSEMARY JACOB BURTNER							2. Date of Death Month April Day 3 Year 2007	3. Time of Death 8:18 PM	
	4a. Facility Name (If not institution, give street and number) WASHINGTON COUNTY HOSPITAL			4b. City, Town, or Location of Death HAGERSTOWN			4c. County of Death WASHINGTON			
Funeral Director	5. Social Security Number 007-10-1046	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) Yrs. 91	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) SEPT. 6, 1915	9. Birthplace (State or Foreign Country) MARYLAND			
	10a. State MARYLAND			10b. County WASHINGTON			10c. City, Town or Location BOONSBORO			
10e. Street and Number 18642 MANOR CHURCH ROAD				10f. Zip Code 21713			10g. Citizen of What Country? U.S.A.			
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: WHITE		14. Race - American Indian, Black, White, etc. Specify:		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) TEACHER			16b. Kind of Business/Industry PUBLIC SCHOOLS				
17. Father's Name (First, Middle, Last) JACOB HARP BURTNER				18. Mother's Name (First, Middle, Maiden Surname) MARY JULIA FRIEND						
19a. Informant's Name/Relationship (Type, Print) NANCY ECKSTINE/NIECE				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 18642 MANOR CHURCH ROAD, BOONSBORO, MARYLAND 21713						
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) BOONSBORO CEMETERY			20b. Place of Disposition (Name of cemetery, crematory or other place) BOONSBORO CEMETERY			Date 4/06/2007	20c. Location - City or Town, State BOONSBORO, MARYLAND			
21. Signature of Funeral Service Licensee Paul M. Dean			22. Name and Address of Facility BAST FUNERAL HOME			7606 Old National Pike Boonsboro, Maryland 21713				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last									Approximate Interval Between Onset and Death minutes	
<p>a. <i>probable acute myocardial infarction</i> Due to (or as a consequence of):</p> <p>b. <i>coronary artery disease</i> Due to (or as a consequence of):</p> <p>c. _____ Due to (or as a consequence of):</p> <p>d. _____ Due to (or as a consequence of):</p>										
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown			23c. If yes, outcome pf pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year				
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
									24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide			28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred			
			28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
29b. Signature and title of certifier Dr Guedenot			29c. License number D32518			29d. Date signed (Month, Day, Year) 4/8/07				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr Guedenot 21 Wyand Dr. Reedysville Maryland 21756										
31. Date filed (Month, Day, Year) APR 06 2007			32. Registrar's Signature Dean D. Dean							

Baltimore, Maryland 21215-0036

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 12213

1 - For State Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Mary Annabell Brooks							2. Date of Death Month April	3. Time of Death Day Year 4 2007 00:25 AM	
	4a. Facility Name (If not institution, give street and number) Washington County Hospital			4b. City, Town, or Location of Death Hagerstown			4c. County of Death Washington County			
Funeral Director	5. Social Security Number 220-16-0666	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 83 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) Aug 10 1923	9. Birthplace (State or Foreign Country) Maryland			
To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State Maryland 10b. County Washington				10c. City, Town or Location Hagerstown			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
	10e. Street and Number 55 E. Washington Street			10f. Zip Code 21740			10g. Citizen of What Country? U.S.A.			
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: Specify: black			14. Race - American Indian, Black, White, etc. Specify: black		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 6		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker			16b. Kind of Business/Industry Personal Residence				
	17. Father's Name (First, Middle, Last) Roy Keets				18. Mother's Name (First, Middle, Maiden Surname) Lottie Keets					
	19a. Informant's Name/Relationship (Type. Print) Geraldine E. Johnson (niece)			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 40 Manor Drive Hagerstown Maryland 21740						
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) Rose Hill Cemetery		20b. Place of Disposition (Name of cemetery, crematory or other place) Rose Hill Cemetery			Date Apr 7 2007	20c. Location - City or Town, State Hagerstown Maryland			
Physician /Medical Examiner	21. Signature of Funeral Service Licensee <i>Douglas A. Fiery</i>			22. Name and Address of Facility Douglas A. Fiery Funeral Home 1331 Eastern Blvd. N. Hagerstown Maryland 21742						
To Be Completed by Physician/Medical Examiner	23a. Part 1. Enter the disease, or complication(s) that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last									
	a. <i>Acute on chronic respiratory failure</i> Due to (or as a consequence of):									
	b. <i>Chronic neuromuscular disease, unspecified</i> Due to (or as a consequence of):									
	c. <i>Severe malnutrition</i> Due to (or as a consequence of):									
	d.									
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year				
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									
	23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown									
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No									
	26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)									
	27. Manner of death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide									
	28a. Date of Injury (Month, Day Year)			28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred				
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)						
	29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
	29b. Signature and title of certifier <i>JUDITH M BAQUERO, MD</i>			29c. License number D62588			29d. Date signed (Month, Day, Year) April 4th, 2007			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JUDITH M BAQUERO, MD, 251 E. ANTIBES ST. HAGERSTOWN, MD									
	31. Date filed (Month, Day, Year) APR 05 2007			32. Registrar's Signature <i>Jean S. Speer</i>						

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit slip.

Medical Certification: To Be Completed by Physician/Medical Examiner

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene
Certificate of Death

Reg. No.

2007 12214

1- For
State
Registrar

		1. Decedent's Name (First, Middle, Last)				2. Date of Death			3. Time of Death		
		THELMA MARIE BISER				Month Day Year			Reg. No.		
Physician /Medical Examiner		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of Death			4c. County of Death				
		WASHINGTON COUNTY HOSPITAL		HAGERSTOWN			WASHINGTON				
Funeral Director		5. Social Security Number	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) Yrs.	If Under 1 Year Months Days Hours Min.	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)			
		220-28-2749		77			FEB. 26, 1930	MARYLAND			
To Be Completed by Funeral Director		Usual Residence of Decedent				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
		10a. State MARYLAND	10b. County WASHINGTON	10c. City, Town or Location BOONSBORO							
		10e. Street and Number 6038 ROHRERSVILLE ROAD				10f. Zip Code 21713		10g. Citizen of What Country? U.S.A.			
		11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: WHITE			
		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) STITCHER			16b. Kind of Business/Industry SHOE MANUFACTURING				
		17. Father's Name (First, Middle, Last) JOSHUA PAUL BISER				18. Mother's Name (First, Middle, Maiden Surname) MARY VIOLA POFFENBERGER					
		19a. Informant's Name/Relationship (Type, Print) PAUL D. BISER/NEPHEW			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 212 POTOMAC STREET, BOONSBORO, MARYLAND 21713						
		20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) BOONSBORO CEMETERY		Date 4/07/2007	20c. Location - City or Town, State BOONSBORO, MARYLAND				
		21. Signature of Funeral Service Licensee ▶ Paul M. Dean		22. Name and Address of Facility BAST FUNERAL HOME		7606 Old National Pike Boonsboro, Maryland 21713					
		23a. Part I. Enter the disease, complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.						Approximate Interval Between Onset and Death			
		Immediate Cause (Final disease or condition resulting in death) Pneumonia									
		Sequel/Silly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last myelodysplastic syndrome									
		a. Due to (or as a consequence of): myelodysplastic syndrome									
		b. Due to (or as a consequence of): myelodysplastic syndrome									
		c. Due to (or as a consequence of): myelodysplastic syndrome									
		d. Due to (or as a consequence of): myelodysplastic syndrome									
		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome pf pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____ <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year					
		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown			
		25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA			Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
		27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred			
				28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)					
		29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
		29b. Signature and title of certifier ▶ James Murphy		29c. License number 9060396		29d. Date signed (Month, Day, Year) 04/04/07					
		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) FARID MURRAY		n 26 6 p a ct							
		31. Date filed (Month, Day, Year) APR 05 2007		32. Registrar's Signature James D. Spence							
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.											

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 12215

1- For State Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) MARY E BECKER					2. Date of Death Month Day Year March 29, 2007	3. Time of Death 12:48 A M
	4a. Facility Name (If not institution, give street and number) Frederick Memorial Hospital			4b. City, Town, or Location of Death Frederick		4c. County of Death Frederick	
Funeral Director	5. Social Security Number 140-22-9158	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 79 Yrs.	If Under 1 Year Months Days Hours Min.	8. Date of Birth (Month, Day, Year) Jun 22, 1927	9. Birthplace (State or Foreign Country) New Jersey	
To Be Completed by Funeral Director	10a. State Maryland 10b. County Frederick 10c. City, Town or Location Brunswick					10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	10e. Street and Number 202 4th Avenue			10f. Zip Code 21716		10g. Citizen of What Country? USA	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) 5+ Teacher		16b. Kind of Business/Industry Education		
	17. Father's Name (First, Middle, Last) Edwin Alden Ferris			18. Mother's Name (First, Middle, Maiden Surname) Philippa Donald Coram			
	19a. Informant's Name/Relationship (Type, Print) Karin Becker Tome/daughter			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 206 4th Avenue Brunswick, MD 21716			
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Chesapeake Crematory		Date 03/30/07	20c. Location - City or Town, State Beltsville, MD
	21. Signature of Funeral Service Licensee ► Beverly L. Heckrotte			22. Name and Address of Facility Going Home Cremation Service P.O. Box 784 MO1251 Beverly L. Heckrotte, P.A. Clarksville, MD 21029			
Physician /Medical Examiner	<p>23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.</p> <p>Immediate Cause (Final disease or condition resulting in death)</p> <p>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</p> <p>a. Due to (as a consequence of): Respiratory Failure</p> <p>b. Due to (as a consequence of): Severe COPD exacerbation.</p> <p>c. Due to (as a consequence of): End stage lung disease</p> <p>d.</p> <p>Approximate Interval Between Onset and Death 10 Hrs.</p> <p>2 days</p> <p>5 years</p>						
Medical Certification: To Be Completed by Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown			23c. If yes, outcome pf pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) _____			23d. Date of delivery Month Day Year
	<p>Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.</p> <p>Hypercapnia, Tachycardia, Emphysema</p> <p>23e. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown</p> <p>24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</p> <p>24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</p>						
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred
			28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.						
	29b. Signature and title of certifier ► Pratima Pandey		29c. License number MD 64910		29d. Date signed (Month, Day, Year) 3/29/2007		
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Pratima Pandey, M.D. 400 W. 7th Street Frederick, MD 21701						
State Registrar	31. Date filed (Month, Day, Year) APR 03 2007		32. Registrar's Signature Pratima Pandey				

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

1242

31. Date filed (Month, Day, Year) APR 03 2007		32. Registrar's Signature Pratima Pandey	
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07-02695

John Henry Barber

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2007 12216

Certificate of Death

Reg. No.

1- For State
RegistrarPhysician/
Medical Examiner

1. Decedent's Name (First, Middle, Last)

John Henry Barber

2. Date of Death

Month

Day

Year

April 8, 2007

3. Time of Death

0122 hrs

Funeral
Director

4a. Facility Name (if not institution, give street and number)

Baltimore Washington Medical Center

4b. City, Town, or Location of Death

Glen Burnie

4c. County of Death

Anne Arundel

5. Social Security Number

085-26-6513

6. Sex

 M F

7. Age (In yrs. last birthday)

72

Yrs.

If Under 1 Year

Months

Days

Hours

Min.

8. Date of Birth (MM/DD/YYYY)

Mar. 11, 1935

9. Birthplace (State or
Foreign Country)

New York

Usual Residence of Decedent

10a. State

MD

10b. County

Anne Arundel

10c. City, Town or Location

Glen Burnie

10d. Inside City Limits

 Yes No

10e. Street and Number

397 Jaybea Court

10f. Zip Code

21061

10g. Citizen of What Country?

USA

11. Marital Status

1 Never Married2 Married3 Widowed4 Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 Yes2 No

If Yes, Give Year

or Dates:

1952-56

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 Yes2 No

Specify:

White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done

during most of working life. DO NOT use retired)

12

Contractor

16b. Kind of Business/Industry

Home Improvements

17. Father's Name (First, Middle, Last)

Claire Barber

18 Mother's Name (First, Middle, Maiden Surname)

Verona Witherill

19a. Informant's Name/Relationship (Type, Print)

Bette A. Barber/wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

397 Jaybea Court Glen Burnie, MD 21061

20a. Method of Disposition

1 Burial2 Cremation3 Removal from State

20b. Place of Disposition (Name of cemetery,

crematory or other place)

Date

20c. Location - City or Town, State

4 Donation5 Other Specify:

Chesapeake Crematory

04/11/07

Beltsville, MD

21. Signature of Funeral Service Licensee

Beverly L. Heckrotte

22. Name and Address of Facility

Going Home Cremation Service P.O. Box 784

Beverly L. Heckrotte, P.A. Clarksville, MD 21029

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Hypertensive cardiovascular disease complicated by pneumonia

Due to (or as a consequence of):

Approximate Interval

Between Onset and

Death

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

 UNPENDED AMENDED

#23a,27,perME, g866, 4/19/07 TT

X

AMENDED

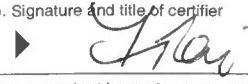
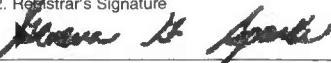
#23a,27,perME, g866,

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 12217

1 For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) John Frederick Crawford							2. Date of Death Month Day Year MARCH 31, 2007 6:35P M	3. Time of Death
	4a. Facility Name (If not institution, give street and number) Saint Joseph Medical Center			4b. City, Town, or Location of Death Towson			4c. County of Death Baltimore		
Funeral Director	5. Social Security Number 312-18-7487	6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) 85 Yrs.	If Under 1 Year Months Days Hours Min.	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Oct 17, 1921	9. Birthplace (State or Foreign Country) PA		
To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State MD 10b. County Carroll 10c. City, Town or Location Westminster							10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
	10e. Street and Number 530 Geneva Drive			10f. Zip Code 21157			10g. Citizen of What Country? USA		
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: 1942 1945	13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. White			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 5+		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Purchasing Agent			16b. Kind of Business/Industry Baltimore County Board of Ed			
	17. Father's Name (First, Middle, Last) Robert Eugene Crawford			18. Mother's Name (First, Middle, Maiden Surname) Mabel Hoffman					
	19a. Informant's Name/Relationship (Type, Print) Lois Crawford/wife			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 530 Geneva Drive Westminster, MD 21157					
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Pipe Creek Cem		Date 4/05/2007	20c. Location - City or Town, State Linwood, MD			
	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Pitts Funeral Home and Chapel, P.A. 412 Washington Rd Westminster, MD 21157			Approximate Interval Between Onset and Death			
	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								
	<p>a. CORONARY ARTERY DISEASE Due to (or as a consequence of):</p> <p>b. _____ Due to (or as a consequence of):</p> <p>c. _____ Due to (or as a consequence of):</p> <p>d. _____</p>								
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome pf pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 4 <input type="checkbox"/> Pregnant at time of death 9 <input type="checkbox"/> Unknown 3 <input type="checkbox"/> Ectopic pregnancy 5 <input type="checkbox"/> Other (specify) _____			23d. Date of delivery Month Day Year			
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. STATUS POST CARDIAC BYPASS SURGERY								
	23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown								
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred			
			28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician 2 <input checked="" type="checkbox"/> Medical Examiner		29b. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.						
	29b. Signature And title of certifier 		29c. License number D28244			29d. Date signed (Month, Day, Year) 4-2-07			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) FOWZIA TAQI M.D. 7601 OSLER DRIVE TOWSON, MARYLAND 21204								
State Registrar	31. Date filed (Month, Day, Year) APR 04 2007		32. Registrar's Signature 						

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

70
new

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2007 12218

Physician /Medical Examiner		1. Decedent's Name (First, Middle, Last) VIRGINIA E. CARTER						2. Date of Death Month Day Year MARCH 28 2007		3. Time of Death 5:17 PM		
Funeral Director		4a. Facility Name (If not institution, give street and number) HARFORD MEMORIAL HOSPITAL			4b. City, Town, or Location of Death HAVRE DE GRACE			4c. County of Death HARFORD				
To Be Completed by Funeral Director		5. Social Security Number 228-28-8305		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 82 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) OCT 4, 1924	9. Birthplace (State or Foreign Country) VIRGINIA			
		Usual Residence of Decedent		10a. State MARYLAND		10b. County HARFORD		10c. City, Town or Location HAVRE DE GRACE			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
		10e. Street and Number 415 S. MARKET STREET					10f. Zip Code 21078			10g. Citizen of What Country? USA		
		11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: BLACK			14. Race - American Indian, Black, White, etc.		
		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) PRODUCTION WORKER			16b. Kind of Business/Industry SHOE MANUFACTURER					
		17. Father's Name (First, Middle, Last) BUCK HUBBARD					18. Mother's Name (First, Middle, Maiden Surname) CHANNIE REYNOLDS					
		19a. Informant's Name/Relationship (Type, Print) RENAY CASEY / GRANDDAUGHTER		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2120 CEDAR DRIVE, APT J, EDGEWOOD, MD 21040								
		20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) HARFORD MEMORIAL GARDENS		20b. Place of Disposition (Name of cemetery, crematory or other place) 4/4/07			20c. Location - City or Town, State ABERDEEN, MD					
		21. Signature of Funeral Service Licensee <i>Lisa Scott - Coleman</i>		22. Name and Address of Facility LISA SCOTT FUNERAL HOME, P.A. 552 LEWIS STREET, HAVRE DE GRACE, MD 21078								
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		23b. Due to (or as a consequence of): <i>ACUTE HOSPITAL INJURY</i>						Approximate Interval Between Onset and Death				
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		23c. Due to (or as a consequence of):										
23d. Date of delivery Month Day Year												
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown						23d. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown				
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.												
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)										
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year) 28b. Time of Injury M			28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No			28d. Describe how injury occurred				
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.												
29b. Signature and title of certifier <i>Thomas A. Brown Jr.</i>		29c. License number D42800			29d. Date signed (Month, Day, Year) 3/30/07							
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Thomas A. Brown Jr. 319 S Union Ave, Hagerstown, MD 21078</i>												
31. Date filed (Month, Day, Year) APR 4 2007		32. Registrar's Signature <i>Thomas A. Brown Jr.</i>										

Division of Vital Records, P.O. Box 68760,

[To the Hospital or Attending Physician]: The law requires that the death certificate be executed

**Physician
/Medical
Examiner**

**Funeral
Director**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Item 23a or 28e-1 show any injury or other traumatic event, **the Medical Examiner must be notified at once.**

**Physician
/Medical
Examiner**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed by the funeral director, page 2 should be detached for use as the burial/transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or Item 23a or 28e-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

5

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2007 12219

Reg. No.

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Stephen Leonard Chulick						2. Date of Death Month MARCH Day 28 Year 2007			3. Time of Death 8:10 AM	
	4a. Facility Name (If not institution, give street and number) Holy Cross Hospital			4b. City, Town, or Location of Death Silver Spring			4c. County of Death Montgomery				
Funeral Director	5. Social Security Number 184-16-4383		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 85 Yrs.	If Under 1 Year Months <input type="checkbox"/> Days	If Under 24 Hrs. Hours <input type="checkbox"/> Min.	8. Date of Birth (Month, Day, Year) June 6, 1921	9. Birthplace (State or Foreign Country) Pennsylvania			
	10a. State Maryland			10b. County Prince George's	10c. City, Town or Location College Park			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
10e. Street and Number 4812 Nantucket Road					10f. Zip Code 20740		10g. Citizen of What Country? United States				
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: 1942-1946			13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Computer Programmer			16b. Kind of Business/Industry Federal Government						
17. Father's Name (First, Middle, Last) Philip Chulick					18. Mother's Name (First, Middle, Maiden Surname) Catherine Grgic						
19a. Informant's Name/Relationship (Type, Print) Sylvia C. Chulick -wife					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4812 Nantucket Road College Park, Maryland 20740						
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)					20b. Place of Disposition (Name of cemetery, crematory or other place) Metropolitan Crematory		Date 4/2/2007	20c. Location - City or Town, State Alexandria, Virginia			
21. Signature of Funeral Service Licensee 					22. Name and Address of Facility Donald V. Borgwardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Maryland 20705						
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)								Approximate Interval Between Onset and Death		
	<p>a. ISCHEMIC STROKE Due to (or as a consequence of):</p> <p>b. HYPERTENSION Due to (or as a consequence of):</p> <p>c. PERIPHERAL ARTERIAL DISEASE Due to (or as a consequence of):</p> <p>d.</p>								1 WEEK		
	23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown								23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Unknown	23d. Date of delivery Month Day Year	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ASPIRATION PNEUMONIA OCULAR NYSTHENIA GRANIS								23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								26. Place of Death (Check only one) <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)	23f. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide								28a. Date of Injury (Month, Day, Year) <input type="checkbox"/> Time of Injury M 28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)								28f. Location (Street and Number or Rural Route Number, City or Town, State)		
	29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								29c. License number D55559	29d. Date signed (Month, Day, Year) MARCH 28, 2007	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) THOMAS HASLWANTER, 7525 GREENBELT CENTER DR, # 314, GREENBELT, MD 20770										
	31. Date filed (Month, Day, Year) APR 03 2007				32. Registrar's Signature 						

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

permits. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
 Important: If item 27 is marked other than "natural", or items 23a or 28a show any injury or other traumatic event, a Medical Examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 12220

1- For State Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Lois T. Cranford					2. Date of Death Month Month Day Year March 30, 2007	3. Time of Death 11:40 AM		
	4a. Facility Name (If not institution, give street and number) Southern Maryland Hospital Center		4b. City, Town, or Location of Death Clinton			4c. County of Death Prince George's			
Funeral Director	5. Social Security Number 165-22-4572	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 80 Yrs.	If Under 1 Year Months Days Hours Min.	8. Date of Birth (Month, Day, Year) Aug 13, 1926		9. Birthplace (State or Foreign Country) Pennsylvania		
To Be Completed by Funeral Director	10a. State MD		10b. County Calvert	10c. City, Town or Location Owings			10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
	10e. Street and Number 9125 Megatha Lane			10f. Zip Code 20736		10g. Citizen of What Country? USA			
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker			16b. Kind of Business/Industry Own Home			
	17. Father's Name (First, Middle, Last) Remo Trifelli				18. Mother's Name (First, Middle, Maiden Surname) Maria Pasquali				
	19a. Informant's Name/Relationship (Type, Print) Jennifer Robinson (daughter)			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9125 Megatha Lane Owings, MD 20736			20c. Location - City or Town, State Cheltenham, MD		
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Maryland Veterans Cem		Date Apr 5 2007				
	21. Signature of Funeral Service Licensee Gary J. Goff				22. Name and Address of Facility Lee Funeral Home Calvert, PA 8125 Southern Maryland Blvd. Owings, MD 20736				
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							Approximate Interval Between Onset and Death	
	<p>a. Due to (or as a consequence of): <i>Acute respiratory failure</i></p> <p>b. Due to (or as a consequence of): <i>Pneumonia</i></p> <p>c. Due to (or as a consequence of): <i>Chronic obstructive lung disease</i></p> <p>d.</p>								
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome pf pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) _____			23d. Date of delivery Month Day Year			
Medical Certification: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown	
								24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred			
			28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
	29b. Signature and title of certifier B. S. AMIR MOHAMMAD F. ROLTA, M.D.		29c. License number D 28035			29d. Date signed (Month, Day, Year) 03, 31, 2007			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) B. S. AMIR MOHAMMAD F. ROLTA, M.D. 9135 PINEWAY RD. #310 CLINTON, MD 20735								
State Registrar	31. Date filed (Month, Day, Year) APR 03 2007		32. Registrar's Signature Anne B. Goff						

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

15

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene
Certificate of Death

1- For State Registrar

Reg. No.

2007 1221

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Audrey Myrtle Cox							2. Date of Death Month Day Year March 26 2007	3. Time of Death 1148 M
	4a. Facility Name (If not institution, give street and number) The Memorial Hospital			4b. City, Town, or Location of Death Easton			4c. County of Death Talbot		
Funeral Director	5. Social Security Number 213-18-1162	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 90 Yrs.	If Under 1 Year Months Days Hours Min.	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) November 21, 1916	9. Birthplace (State or Foreign Country) Delaware		
To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State Maryland 10b. County Caroline 10c. City, Town or Location Federalsburg							10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
	10e. Street and Number 26475 Line Road			10f. Zip Code 21632			10g. Citizen of What Country? United States of America		
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: Caucasian			14. Race - American Indian, Black, White, etc. Specify: Caucasian	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11 HS Grad			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Homemaker			16b. Kind of Business/Industry Home		
	17. Father's Name (First, Middle, Last) William Kirwin Smith					18. Mother's Name (First, Middle, Maiden Surname) Sarah Nina Hanson			
	19a. Informant's Name/Relationship (Type, Print) J. Gary Cox Son			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 26475 Line Road, Federalsburg, Maryland 21632					
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) Randolph Moore			20b. Place of Disposition (Name of cemetery, crematory or other place) Denton Cemetery			Date 3/30/2007	20c. Location - City or Town, State Denton, Maryland	
	21. Signature of Funeral Service Licensee Randolph Moore					22. Name and Address of Facility Moore Funeral Home, P.A. 12 South Second Street, Denton, Maryland 21629			
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Congestive heart failure Approximate Interval Between Onset and Death Days								
	23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown								
	23c. If yes, outcome pf pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown <input type="checkbox"/> Other (specify) 23d. Date of delivery Month Day Year								
Medical Certification: To Be Completed by Physician/Medical Examiner	23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown								
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
	26. Place of Death Check only one Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide								
	28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 28d. Describe how injury occurred								
	28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)								
	29a. Certifier <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
	29b. Signature and title of certifier Lakshmi Vaidyanathan MD 29c. License number D057749 29d. Date signed (Month, Day, Year) MARCH 26 2007								
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Lakshmi Vaidyanathan, M.D., 219 South Washington Street, Easton, Maryland 21601								
State Registrar	31. Date filed (Month, Day, Year) MAR 28 2007			32. Registrar's Signature 					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 12222

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>Oakley Robert Councill</i>					2. Date of Death Month Day Year <i>March 20 2007</i>			3. Time of Death 0345 M
	4a. Facility Name (If not institution, give street and number) <i>Memorial Hospital</i>					4b. City, Town, or Location of Death <i>Easton</i>			4c. County of Death <i>Talbot</i>
Funeral Director	5. Social Security Number <i>214-18-4959</i>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <i>82 Yrs.</i>	If Under 1 Year Months Days Hours Min. <i></i>	8. Date of Birth (Month, Day, Year) <i>April 26, 1924</i>	9. Birthplace (State or Foreign Country) <i>Delaware</i>			
	Usual Residence of Decedent 10a. State <i>Maryland</i> 10b. County <i>Caroline</i> 10c. City, Town or Location <i>Denton</i>					10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
To Be Completed by Funeral Director	10e. Street and Number <i>110 South Eighth Street</i>					10f. Zip Code <i>21629</i>	10g. Citizen of What Country? <i>United States of America</i>		
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <i>1945-1946</i>			13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: <i></i>	14. Race - American Indian, Black, White, etc. Specify: Caucasian			
	15. Decedent's Education (Specify only highest grade completed) <i>Elementary/Secondary (0-12) 11 HS Grad</i>			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Mechanic</i>			16b. Kind of Business/Industry <i>Automobile</i>		
	17. Father's Name (First, Middle, Last) <i>Oakley Rollins Councill</i>					18. Mother's Name (First, Middle, Maiden Surname) <i>Ruth Irene Shockley</i>			
	19a. Informant's Name/Relationship (Type, Print) <i>Dale Ann Lord</i>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>Daughter 11644 Holly Road, Ridgely, Maryland 21660</i>					
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <i></i>			20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Denton Cemetery</i>			Date <i>3/23/2007</i>	20c. Location - City or Town, State <i>Denton, Maryland</i>	
Physician /Medical Examiner	21. Signature of Funeral Service Licensee <i>Ronald P. Moore</i>			22. Name and Address of Facility <i>Moore Funeral Home, P.A. 12 South Second Street, Denton, Maryland 21629</i>					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <i>Pneumonia</i> Approximate Interval Between Onset and Death								
	a. Due to (or as a consequence of): <i></i>								
	b. Due to (or as a consequence of): <i></i>								
	c. Due to (or as a consequence of): <i></i>								
	d. Due to (or as a consequence of): <i></i>								
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown			23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown <input type="checkbox"/> Other (Specify) <i></i>			23d. Date of delivery Month Day Year		
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Aneurysm 214 e. e. positive stools</i>								
	23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown								
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No								
Medical Certification: To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
	26. Place of Death Check on one Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide								
	28a. Date of Injury (Month, Day, Year) <i></i> 28b. Time of Injury <i>M</i> 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
	28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) <i></i>								
	28d. Describe how injury occurred <i></i>								
	28f. Location (Street and Number or Rural Route Number, City or Town, State) <i></i>								
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
	29b. Signature and title of certifier <i>Dennis DeShields, M.D.</i>								
	29c. License number <i>DO053110</i>								
	29d. Date signed (Month, Day, Year) <i>March 20, 2007</i>								
State Registrar	31. Date filed (Month, Day, Year) <i>MAR 6 2007</i>			32. Registrar's Signature <i></i>					

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Oakley Council
Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

3-26-17 Amended 19a per fh AS CCHD Certificate of Death

2007 1223

Reg. No.

For
State
RegistrarPhysician
/Medical
Examiner

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Funeral
Director

To Be Completed by Funeral Director

1. Decedent's Name (First, Middle, Last) <i>James Roland Chaffinch, Jr.</i>	2. Date of Death Month Day Year <i>March 18, 2007</i>	3. Time of Death <i>8:50 A M</i>		
4a. Facility Name (If not institution, give street and number) <i>103 Butler Drive</i>	4b. City, Town, or Location of Death <i>Denton</i>	4c. County of Death <i>Caroline</i>		
5. Social Security Number <i>219-14-4211</i>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <i>86 Yrs.</i>	If Under 1 Year Months Days Hours Min. 8. Date of Birth (Month, Day, Year) <i>May 4 1920</i>	9. Birthplace (State or Foreign Country) <i>Maryland</i>
Usual Residence of Decedent 10a. State <i>MD</i> 10b. County <i>Caroline</i> 10c. City, Town or Location <i>Denton</i>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number <i>103 Butler Drive</i>			10f. Zip Code <i>21629</i>	10g. Citizen of What Country? <i>USA</i>
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: <i>WWII</i>	13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: <i>Caucasian</i>	14. Race - American Indian, Black, White, etc.	
15. Decedent's Education (Specify only highest grade completed) <i>Elementary/Secondary (0-12) 7th H.S. Grad</i>	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>College (1-4 or 5+) 4 Banker</i>	16b. Kind of Business/Industry <i>Banking</i>		
17. Father's Name (First, Middle, Last) <i>James Roland Chaffinch, Sr.</i>			18. Mother's Name (First, Middle, Maiden Surname) <i>Lenore Clark Greenley</i>	
19a. Informant's Name/Relationship (Type, Print) <i>Candace Minner Daughter</i>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>423 South Second Street, Denton, Maryland 21629</i>		
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <i>Capital Crematory</i>	20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Capital Crematory</i>	Date <i>3/19/2007</i>	20c. Location - City or Town, State <i>Dover, DE</i>	
21. Signature of Funeral Service Licensee <i>Ronald J. Karpel, Jr.</i>		22. Name and Address of Facility <i>Moore Funeral Home, PA, 125. Second St., Denton, MD 21629</i>		

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		Approximate Interval Between Onset and Death
a. Due to (or as a consequence of): <i>Metastatic prostate cancer</i>		
b. Due to (or as a consequence of):		
c. Due to (or as a consequence of):		
d. Due to (or as a consequence of):		

IF FEMALE:	23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown <input type="checkbox"/> Other (specify) <i>9</i>	23d. Date of delivery Month Day Year
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Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown
		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No

25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)	28d. Describe how injury occurred	
		28f. Location (Street and Number or Rural Route Number, City or Town, State)	

29a. Certifier (Check only one)	1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
------------------------------------	--

29b. Signature and title of certifier <i>Patricia J. Karnes, MD</i>	29c. License number <i>H0056873</i>	29d. Date signed (Month, Day, Year) <i>March 19, 2007</i>
--	--	--

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)		
--	--	--

PATRICIA J. KARNES - AMZIBEL, DO 316 Railroad Ave P.O. Box 122 Goldsboro, MD 21636		
31. Date filed (Month, Day, Year) <i>MAR 21 2007</i>	32. Registrar's Signature <i>Patricia J. Karnes</i>	

State
Registrar

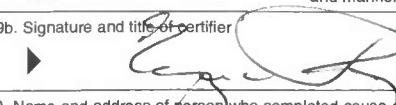
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amend Item 27,29a per dr. g866,04/17/07/dbb Certificate of Death

Reg. No. 2007 12224

1- For State Registrar

Physician /Medical Examiner		1. Decedent's Name (First, Middle, Last) MARY ANNE CLARK				2. Date of Death Month Day Year MARCH 29 2007		3. Time of Death 9:00 AM	
		4a. Facility Name (If not institution, give street and number) Ft. WASHINGTON Health & Rehab				4b. City, Town, or Location of Death FORT WASHINGTON		4c. County of Death Prince Georges	
Funeral Director		5. Social Security Number 579-44-8233	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 88 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) FEB 6, 1919	9. Birthplace (State or Foreign Country) M.D.	
		Usual Residence of Decedent 10a. State MD				10b. County Anne Arundel			
		10c. City, Town or Location Laurel				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
		10e. Street and Number 3046 Old Channel Rd.				10f. Zip Code 20724		10g. Citizen of What Country? USA	
		11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: 1945-1946		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: BLACK		14. Race - American Indian, Black, White, etc. Specify: BLACK	
		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 7		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) NURSE		16b. Kind of Business/Industry PRIVATE DUTY			
		17. Father's Name (First, Middle, Last) Willie C. JACKSON				18. Mother's Name (First, Middle, Maiden Surname) Mildred J. WATSON			
		19a. Informant's Name/Relationship (Type, Print) Dorothy Coleman - daughter		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3046 Old Channel Rd. Laurel, MD 20724		Date 4/3/07		20c. Location - City or Town, State Rutherford Glen, VA	
		20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) Ebenezer Bapt. C.		20b. Place of Disposition (Name of Cemetery, crematory or other place) Ebenezer Bapt. C.					
		21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Henry W. Gibney Funeral Home P.O. Box 528 Ashland, Virginia 23005			
		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)				Approximate Interval Between Onset and Death			
		a. Due to (or as a consequence of): Respiratory Failure b. Due to (or as a consequence of): Advanced Leukemia							
		c. Due to (or as a consequence of):							
		d. Due to (or as a consequence of):							
		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome pf pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown <input type="checkbox"/> Other (specify) Unknown		23d. Date of delivery Month Day Year			
		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Pneumonia Thrombocytopenia				23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown			
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
		25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death Check one Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year) M		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
				28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 1328 South St. - Ave SC - Wash. DC 20032		28d. Describe how injury occurred			
		29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29c. License number D42955		29d. Date signed (Month, Day, Year) Apr 3, 2007			
		29b. Signature and title of certifier 							
		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1328 South St. - Ave SC - Wash. DC 20032							
		31. Date filed (Month, Day, Year) APR 17 2007		32. Registrar's Signature 					

Baltimore, Maryland 21215-0036

Submit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division or Vital Records, P.O. Box 68760,

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 12225

1- For State Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Kelvin F. Dade							2. Date of Death Month April Day 7 Year 2007	3. Time of Death 11:45P M
	4a. Facility Name (If not institution, give street and number) 4007 Murdock Street			4b. City, Town, or Location of Death Temple Hills			4c. County of Death Prince Georges		
Funeral Director	5. Social Security Number 579-64-5452		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 57 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) March 22, 1950	9. Birthplace (State or Foreign Country) Wash., DC	
	Usual Residence of Decedent		10a. State Md. 10b. County PG			10c. City, Town or Location Temple Hills			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
To Be Completed by Funeral Director	10e. Street and Number 4007 Murdock Street			10f. Zip Code 20748			10g. Citizen of What Country? United States		
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No.) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Driver		16b. Kind of Business/Industry Private				
	17. Father's Name (First, Middle, Last) Joseph Lancaster				18. Mother's Name (First, Middle, Maiden Surname) Lillie White				
	19a. Informant's Name/Relationship (Type, Print) Carolyn Wellington/sister				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5260 Daventry Terrace Forestville, Md. 20747				
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) Hodges & Edwards F.H.				20b. Place of Disposition (Name of cemetery, crematory or other place) Riverdale Crematory 4/10/07				
	21. Signature of Funeral Service Licensee Prince Edwards				20c. Location - City or Town, State Riverdale, Md.				
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)				23d. Approximate Interval Between Onset and Death				
	23b. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								
	23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Unknown				23d. Date of delivery Month Day Year				
	23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown				23f. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. hyperlipidemia				
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
Physician /Medical Examiner	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
Medical Certification: To Be Completed by Physician/Medical Examiner	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide				28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred
					28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
	29a. Signature and title of certifier Debra A. Vereen MD				29c. License number D55538		29d. Date signed (Month, Day, Year) 4/10/07		
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DEBRA A. VEREEN MD 1458 Addison Road S. Capitol Heights, MD 20793								
State Registrar	31. Date filed (Month, Day, Year) APR 17 2007		32. Registrar's Signature Debra A. Vereen						

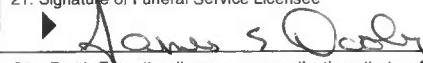
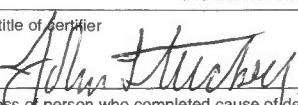
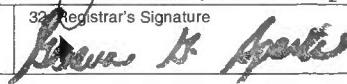
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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 12226

1- For State Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Justin Paul Dunlavey							2. Date of Death Month Day Year March 31, 2007	3. Time of Death 1:00 PM	
	4a. Facility Name (If not institution, give street and number) 3142 Gracefield Road, MG 420				4b. City, Town, or Location of Death Silver Spring			4c. County of Death Montgomery		
Funeral Director	5. Social Security Number 070-07-6959		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 89 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Nov. 11, 1917	9. Birthplace (State or Foreign Country) New York		
	Usual Residence of Decedent Maryland		10a. State Maryland			10b. County Montgomery			10c. City, Town or Location Silver Spring	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
To Be Completed by Funeral Director	10e. Street and Number 3142 Gracefield Road, MG 420				10f. Zip Code 20904			10g. Citizen of What Country? USA		
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: 1940-77			13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 5+			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Patent Attorney			16b. Kind of Business/Industry US Department of Navy			
	17. Father's Name (First, Middle, Last) Robert Joseph Dunlavey				18. Mother's Name (First, Middle, Maiden Surname) Mary Ellen Hasset					
19a. Informant's Name/Relationship (Type, Print) Thomas J. Dunlavey/ Son				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1102 Azalea Drive, Rockville, Maryland 20850						
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Gate of Heaven Cemetery			Date April 4, 2007	20c. Location - City or Town, State Silver Spring, Maryland			
21. Signature of Funeral Service Licensee 				22. Name and address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd, W, Silver Spring, MD 20901						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)				23b. If yes, outcome pf pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) _____ 9 <input type="checkbox"/> Unknown					Approximate Interval Between Onset and Death	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				23c. Due to (or as a consequence of): a. Prostate Cancer b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):						
23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year							
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Anemia, Diarrhea, Dementia									23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
									24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred		
				28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
29b. Signature and title of Certifier 				29c. License number d23649			29d. Date signed (Month, Day, Year) April 2, 2007			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) John Stuckey, M.D 3142 Gracefield Road, Silver Spring, MD 20904										
31. Date filed (Month, Day, Year) APR 03 2007			32. Registrar's Signature 							

Baltimore, Maryland 21215-0036
 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
 Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

V+1

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene
Certificate of Death

Reg. No. 2007 12227

1- For State Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) RICHARD LEE DERR, SR.						2. Date of Death Month April Day 1 Year 2007	3. Time of Death 11.43 P M	
	4a. Facility Name (If not institution, give street and number) WASHINGTON COUNTY HOSPITAL			4b. City, Town, or Location of Death HAGERSTOWN			4c. County of Death WASHINGTON		
Funeral Director	5. Social Security Number 220-28-8973	6. Sex 1 X M 2 □ F	7. Age (In yrs. last birthday) 71 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Hours	8. Date of Birth (Month, Day, Year) DEC. 12, 1935	9. Birthplace (State or Foreign Country) MARYLAND		
To Be Completed by Funeral Director	10a. State MARYLAND 10b. County WASHINGTON 10c. City, Town or Location HAGERSTOWN						10d. Inside City Limits 1 X Yes 2 □ No		
	10e. Street and Number 232 DEVONSHIRE ROAD			10f. Zip Code 21740			10g. Citizen of What Country? U.S.A.		
	11. Marital Status 1 □ Never Married 2 X Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 X No If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 □ Yes 2 X No Specify:			14. Race - American Indian, Black, White, etc. Specify: WHITE	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) DRIVER			16b. Kind of Business/Industry PLUMBING SUPPLY CO.		
	17. Father's Name (First, Middle, Last) CLIFFORD PHILLIP DERR						18. Mother's Name (First, Middle, Maiden Surname) VIRGIE ELEANOR DEWITT		
	19a. Informant's Name/Relationship (Type, Print) NANCY A. DERR, WIFE			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 232 DEVONSHIRE ROAD, HAGERSTOWN, MARYLAND 21740					
	20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) BOONSBORO CEMETERY			Date 4/5/2007	20c. Location - City or Town, State BOONSBORO, MARYLAND	
	21. Signature of Funeral Service Licensee Paul M. Dean						22. Name and Address of Facility BAST FUNERAL HOME 7606 OLD NATIONAL PIKE BOONSBORO, MARYLAND 21713		
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								
	<p>a. Due to (or as a consequence of): Fung Cancer</p> <p>b. Due to (or as a consequence of): Pneumonia</p> <p>c. Due to (or as a consequence of): Renal Failure</p> <p>d.</p>								
	Approximate Interval Between Onset and Death								
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 X No 9 □ Unknown			23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify) 9 □ Unknown			23d. Date of delivery Month Day Year		
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Diabetes Peripheral Vascular Disease								
	23e. Did tobacco use contribute to the cause of death? 1 □ Yes 2 □ No 3 □ Probably 4 X Unknown								
	24a. Was an autopsy performed? 1 □ Yes 2 X No								
	24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 X No								
Medical Certification: To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 □ Yes 2 X No								
	26. Place of Death (Check only one) Hospital: 1 X Inpatient 2 □ ER/Outpatient 3 □ DOA Other: 4 □ Nursing Home 5 □ Residence 6 □ Other (Specify)								
	27. Manner of Death 1 X Natural 5 □ Pending investigation 2 □ Accident 6 □ Could not be determined 3 □ Suicide 4 □ Homicide								
	28a. Date of Injury (Month, Day Year) M 28b. Time of Injury M 28c. Injury at Work? 1 □ Yes 2 □ No 28d. Describe how injury occurred								
	28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)								
	28f. Location (Street and Number or Rural Route Number, City or Town, State)								
	29a. Certifier (Check only one) 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 □ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
	29b. Signature and title of certifier Vincent A. Cantone								
	29c. License number D50362								
	29d. Date signed (Month, Day, Year) April 2, 2007								
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Vincent A. Cantone M.D. 22911 Jefferson Blvd., Smithsburg, Maryland 21782								
State Registrar	31. Date filed (Month, Day, Year) APR 04 2007	32. Registrar's Signature James D. Spotts							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

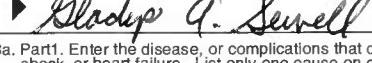
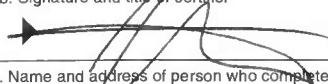
REPLACEMENT

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007-12228

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last)						2. Date of Death Month Day Year	3. Time of Death 09:00 A M			
	Mary Susie Emerson						Mar 29, 2007	Calvert			
Funeral Director	4a. Facility Name (If not institution, give street and number) Calvert Memorial Hospital			4b. City, Town, or Location of Death Prince Frederick			4c. County of Death Calvert				
	5. Social Security Number 214-30-0340	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 73 Yrs.	If Under 1 Year Months Days Hours Min.	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Nov 19, 1933	9. Birthplace (State or Foreign Country) Maryland				
To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State MD 10b. County Calvert 10c. City, Town or Location Owings 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										
	10e. Street and Number 554 Grovers Turn Road			10f. Zip Code 20736			10g. Citizen of What Country? U.S.A.				
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: Black			14. Race - American Indian, Black, White, etc. Specify: Black			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Domestic			16b. Kind of Business/Industry Someone Else's Home				
	17. Father's Name (First, Middle, Last) John Henry Adams				18. Mother's Name (First, Middle, Maiden Surname) Georgia Anna Giles						
	19a. Informant's Name/Relationship (Type, Print) Melvin Emerson, Jr. /Husband			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 554 Grovers Turn Road Owings, MD 20736							
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) Apostolic Faith Church Cemetery			20b. Place of Disposition (Name of cemetery, crematory or other place) Apostolic Faith Church Cemetery			Date 04/05/07	20c. Location - City or Town, State Owings, MD			
Physician /Medical Examiner	21. Signature of Funeral Service Licensee 			22. Name and Address of Facility Sewell Funeral Home 1451 Dares Beach Road Prince Frederick, MD 20678							
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death		
	<p>a. Intra Abdominal Sepsis Due to (or as a consequence of):</p> <p>b. Pulmonary Embolus Due to (or as a consequence of):</p> <p>c. Duodenal Perforation Due to (or as a consequence of):</p> <p>d. ESOPHAGEAL CANCER</p>										
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome pf pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown <input type="checkbox"/> Other (specify) _____						23d. Date of delivery Month Day Year		
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23e. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
									24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
									24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred			
			28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
	29b. Signature and title of certifier 		29c. License number 1461922						29d. Date signed (Month, Day, Year) 6/15/07		
	31. Date filed (Month, Day, Year) JUL 05 2007		32. Registrar's Signature 								

Baltimore, Maryland 21215-0036

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 12229

1 - For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Marian Elizabeth EBERHART							2. Date of Death Month Day Year April 4 2007	3. Time of Death 9:20 a M
	4a. Facility Name (If not institution, give street and number) Homewood Retirement Center				4b. City, Town, or Location of Death Williamsport			4c. County of Death Washington	
Funeral Director	5. Social Security Number 178-05-4740	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 96 Yrs.	If Under 1 Year Months Days Hours Min. 	If Under 24 Hrs. 	8. Date of Birth (Month, Day, Year) June 23 1910	9. Birthplace (State or Foreign Country) Pennsylvania		
	Usual Residence of Decedent 10a. State Maryland 10b. County Washington				10c. City, Town or Location Williamsport			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
To Be Completed by Funeral Director	10e. Street and Number 16505 Virginia Avenue				10f. Zip Code 21795		10g. Citizen of What Country? USA		
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: 		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: 		14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 0		16b. Kind of Business/Industry Homemaker		16c. Location - City or Town, State Her own home	
	17. Father's Name (First, Middle, Last) George Aaron Reed				18. Mother's Name (First, Middle, Maiden Surname) Amanda Farnsworth				
	19a. Informant's Name/Relationship (Type, Print) Donald Williams - Son			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 43 Hidden Valley Drive, Newark, Delaware 19711					
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <i>Scott M. Minich</i>			20b. Place of Disposition (Name of cemetery, crematory or other place) Hagerstown Crematory		Date 4/8/07	20c. Location - City or Town, State Hagerstown, Maryland		
	21. Signature of Funeral Service Licensee <i>Scott M. Minich</i>				22. Name and Address of Facility Minnich Funeral Home 415 E. Wilson Blvd. Hagerstown, Md. 21740				
	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. pneumonia Due to (or as a consequence of): b. chronic obstructive lung disease Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____								Approximate Interval Between Onset and Death 4 days
	23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown			23c. If yes, outcome pf pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year		
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. congestive heart failure								23e. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide			28a. Date of Injury (Month, Day, Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred		
				28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.			29c. License number D47451					29d. Date signed (Month, Day, Year) Apr. 14, 2007
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Cynthia Kuttner-Sands, MD, 16505 Virginia Avenue, Williamsport, Maryland 21795								
State Registrar	31. Date filed (Month, Day, Year) APR 05 2007			32. Registrar's Signature <i>Janet A. Spangler</i>					

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Baltimore, Maryland 21215-0036

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 Important: If item 27 is marked other than "natural", or items 23a or 28e show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2007 12230

1- For State Registrar

Physician /Medical Examiner

Funeral Director

To Be Completed by Funeral Director

1. Decedent's Name (First, Middle, Last)				2. Date of Death Month Day Year				3. Time of Death			
Stuart Alan Engle				April 1 2007				5:40 A M			
4a. Facility Name (If not institution, give street and number) 24620 Pealiquor Road				4b. City, Town, or Location of Death Denton				4c. County of Death Caroline			
5. Social Security Number 216-38-9463		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 65 Yrs.		If Under 1 Year Months Days Hours Min.		8. Date of Birth (Month, Day, Year) October 10, 1941		9. Birthplace (State or Foreign Country) Maryland	
Usual Residence of Decedent 10a. State Maryland				10b. County Caroline				10c. City, Town or Location Denton			
10e. Street and Number 24620 Pealiquor Road				10f. Zip Code 21629				10g. Citizen of What Country? United States of America			
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: 1959-1985		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: Caucasian			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 HS Grad				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Officer				16b. Kind of Business/Industry United States Coast Guard			
17. Father's Name (First, Middle, Last) Harvey Secrist Engle				18. Mother's Name (First, Middle, Maiden Surname) Josephine Constance Quidas							
19a. Informant's Name/Relationship (Type, Print) Sandra S. Engle Wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 24620 Pealiquor Road, Denton, Maryland 21629							
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) MD Eastern Shore Veterans' Cemetery				Date 4/3/2007		20c. Location - City or Town, State Hurlock, Maryland	
21. Signature of Funeral Service Licensee → <i>Ronald P. Max</i>				22. Name and Address of Facility Moore Funeral Home, P.A. 12 South Second Street, Denton, Maryland 21629							

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23c. IF FEMALE: Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year		23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown			
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		{		a. Due to (or as a consequence of): <i>PANCREATIC CARCINOMA</i>							
		b. Due to (or as a consequence of):									
		c. Due to (or as a consequence of):									
		d. Due to (or as a consequence of):									
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
		28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)				28d. Describe how injury occurred					
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier <i>Ludwig Engleseder, M.D.</i>		29c. License number D 31466		29d. Date signed (Month, Day, Year) 4/2/07			

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ludwig Engleseder, M.D., 503 Cynwood Drive, Suite 2, Easton, Maryland 21601		31. Date filed (Month, Day, Year) APR 02 2007		32. Registrar's Signature <i>Ronald P. Max</i>	
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Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transit

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

DHMH 17 Rev 1/2001

State Registrar

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 12231

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) CALVIN R. FLAUTT					2. Date of Death Month April Day 4, Year 2007	3. Time of Death 10:30 A M
	4a. Facility Name (If not institution, give street and number) Sunrise Assisted Living			4b. City, Town, or Location of Death Frederick		4c. County of Death Frederick	
Funeral Director	5. Social Security Number 220-40-0285	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 60 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days Hours Min.	8. Date of Birth (Month, Day, Year) July 23, 1946	9. Birthplace (State or Foreign Country) Maryland
To Be Completed by Funeral Director	Usual Residence of Decedent						
	10a. State Maryland	10b. County Frederick	10c. City, Town or Location Frederick				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
10e. Street and Number 990 Waterford Drive				10f. Zip Code 21702	10g. Citizen of What Country? U.S.A.		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 2 Antique Dealer			16b. Kind of Business/Industry Antiques	
17. Father's Name (First, Middle, Last) Gilmore Flautt				18. Mother's Name (First, Middle, Maiden Surname) Hazel Rigler			
19a. Informant's Name/Relationship (Type, Print) Maryann B. Coates/ Ex Wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12171 Wolfsville Road, Myersville, MD 21773			
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <i>Smithsburg Crematory</i>			20b. Place of Disposition (Name of cemetery, crematory or other place) Smithsburg Crematory			Date 4/11/07	20c. Location - City or Town, State Smithsburg, Maryland
21. Signature of Funeral Service Licensee <i>Robert E. Dailey Jr.</i>				22. Name and Address of Facility ROBERT E. DAILEY & SON FUNERAL HOMES, P.A. 1201 NORTH MARKET ST., FREDERICK, MD 21701			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)				Approximate Interval Between Onset and Death <i>Acute myocardial infarction.</i>			
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							
a. Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. _____							
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown				23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____ <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Congestive heart failure</i>				23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
				24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) <i>Assisted living</i>			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide				28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred <i>falling</i>
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29b. Signature and N.I. of certifier <i>Hiren N Shah</i>				29c. License number 051643		29d. Date signed (Month, Day, Year) 4-10-07	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 65 c Thomas Thomson Dr Frederick MD 21702							
31. Date filed (Month, Day, Year) APR 17 2007				32. Registrar's Signature <i>Hiren N Shah</i>			

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Item 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be recalled at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2007 12232

1- For
State
Registrar

Physician
/Medical
Examiner

Funeral
Director

To Be Completed by Funeral Director

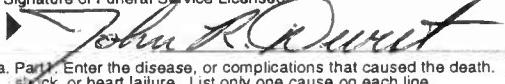
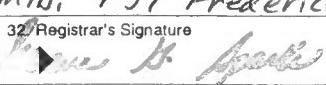
Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or if Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit slip.

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year				3. Time of Death M
Earl E. Finzel, Sr.		March 26, 2007				01:30 A M
4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of Death				4c. County of Death
WMHS - Memorial Campus		Cumberland				Allegany
5. Social Security Number	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 77 Yrs.	If Under 1 Year Months Days Hours Min.	8. Date of Birth (Month, Day, Year) May 15, 1929	9. Birthplace (State or Foreign Country) Maryland	
Usual Residence of Decedent		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				
10a. State Maryland	10b. County Allegany	10c. City, Town or Location Frostburg				
10e. Street and Number 81 East Mechanic Street Apt. 213		10f. Zip Code 21532-				10g. Citizen of What Country? U.S.A.
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: 1947 - 1961	13. Was Decedent of Hispanic Origin? (Specify Yes or No) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	14. Race - American Indian, Black, White, etc. Specify: White			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 0	16b. Kind of Business/Industry barber				
17. Father's Name (First, Middle, Last) Patrick Ellsworth Finzel		18. Mother's Name (First, Middle, Maiden Surname) Mary Jane Oden				
19a. Informant's Name/Relationship (Type, Print) Earl Finzel, Jr.	son	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17108 Old National Pike Frostburg Maryland 21532				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) Eckhart Cemetery	20b. Place of Disposition (Name of cemetery, crematory or other place)	20c. Location - City or Town, State Date March 28, 2007 Eckhart Maryland				
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		Approximate Interval Between Onset and Death				
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last						
a. Due to (or as a consequence of): <i>Cardiac Arrest</i>						
b. Due to (or as a consequence of): <i>Respiratory Failure</i>						
c. Due to (or as a consequence of): <i>Stage IV Lung Cancer with pleural effusion</i>						
d. Due to (or as a consequence of): <i>Chronic Obstructive Pulmonary Disease</i>						
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown	23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown	23d. Date of delivery Month Day Year				
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23e. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown				
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.	29c. License number D0065083				29d. Date signed (Month, Day, Year) 03/26/07	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Joseph T. Kariyil, M.D. 939 Frederick Street, Cumberland, MD 21502		32. Registrar's Signature 				
31. Date filed (Month, Day, Year) MAR 29 2007	33. Date filed (Month, Day, Year)					

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 12233

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Dorothy Estella Goetz Fries				2. Date of Death Month Day Year March 30, 2007	3. Time of Death 8:45 a M		
	4a. Facility Name (If not institution, give street and number) 6645 Wooded Branch Lane		4b. City, Town, or Location of Death Chesapeake Beach		4c. County of Death Calvert			
Funeral Director	5. Social Security Number 214-30-3842	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 90 Yrs.	If Under 1 Year Months 0	If Under 24 Hrs. Days 0	8. Date of Birth (Month, Day, Year) May 10, 1916	9. Birthplace (State or Foreign Country) Maryland	
	Usual Residence of Decedent 10a. State MD		10b. County Calvert		10c. City, Town or Location Chesapeake Beach		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
To Be Completed by Funeral Director	10e. Street and Number 6645 Wooded Branch Lane			10f. Zip Code 20732		10g. Citizen of What Country? U.S.A.		
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: 12		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: homemaker		14. Race - American Indian, Black, White, etc. Specify: white		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) homemaker		16b. Kind of Business/Industry own home			
	17. Father's Name (First, Middle, Last) George M. Gilbert			18. Mother's Name (First, Middle, Maiden Surname) Lydia Templeman				
	19a. Informant's Name/Relationship (Type. Print) Gloria Collinson, daughter		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6645 Wooded Branch Ln., Chesapeake Beach, MD 20732		Date	20c. Location - City or Town, State Annapolis, MD		
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) Hillcrest Mem. Gardens		20b. Place of Disposition (Name of cemetery, crematory or other place) 04/04/07					
	21. Signature of Funeral Service License Says M. Harbold		22. Name and Address of Facility Rausch Funeral Home, P.A. 8325 Mt. Harmony Lane, Owings, MD 20736					
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		Approximate Interval Between Onset and Death Several years.					
	a. Due to (or as a consequence of): Coronary artery disease							
	b. Due to (or as a consequence of):							
	c. Due to (or as a consequence of):							
	d. Due to (or as a consequence of):							
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome pf pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) 9		23d. Date of delivery Month Day Year			
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Chronic renal failure, Intestinal lung disease							
	23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown							
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DCA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred		
			28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
	29b. Signature and title of certifier Zahid Yousa		29c. License number D0027189		29d. Date signed (Month, Day, Year) 3/30/2007			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ZAHID YOUSAF, 2417 Solomons Island Rd. Huntington, MD 20639							
State Registrar	31. Date filed (Month, Day, Year) APR 02 2007		32. Registrar's Signature Suzanne B. Smith					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2007 12234

Reg. No.

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>Joy Ellen Friend</i>				2. Date of Death Month Day Year <i>April 8, 2007</i>	3. Time of Death <i>500 AM</i>		
	4a. Facility Name (If not institution, give street and number) <i>Garrett County Memorial Hosp.</i>		4b. City, Town, or Location of Death <i>Oakland</i>		4c. County of Death <i>Garrett</i>			
Funeral Director	5. Social Security Number <i>213-44-1985</i>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <i>62 Yrs.</i>	If Under 1 Year Months	If Under 24 Hrs. Days Hours Min.	8. Date of Birth (Month, Day, Year) <i>Nov. 26, 1943</i>	9. Birthplace (State or Foreign Country) <i>Maryland</i>	
	Usual Residence of Decedent				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
To Be Completed by Funeral Director	10a. State <i>MD</i>	10b. County <i>Garrett</i>	10c. City, Town or Location <i>Friendsville</i>			10g. Citizen of What Country? <i>USA</i>		
	10e. Street and Number <i>949 Old River Rd., Apt. E-4</i>				10f. Zip Code <i>21531</i>			
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <i>If Yes, Give Year or Dates:</i>	13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <i>Specify:</i>			14. Race - American Indian, Black, White, etc. <i>Specify: White</i>		
	15. Decedent's Education (Specify only highest grade completed) <i>Elementary/Secondary (0-12) 12</i>	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>College (1-4 or 5+) Disabled</i>	16b. Kind of Business/Industry <i>Disabled</i>					
	17. Father's Name (First, Middle, Last) <i>Ross Friend</i>			18. Mother's Name (First, Middle, Maiden Surname) <i>Elma Fike</i>				
	19a. Informant's Name/Relationship (Type, Print) <i>Thomas E. Casteel/Nephew</i>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>949 Old River Rd., Apt. C-2, Friendsville, MD 21531</i>			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Steele Cemetery</i>		Date <i>April 9, 2007</i>	20c. Location - City or Town, State <i>Friendsville, MD</i>		
Physician /Medical Examiner	21. Signature of Funeral Service Licensee <i>D Lynn Neumann</i>		22. Name and Address of Facility Newman Funeral Homes, P.A. <i>P.O. Box 275, Grantsville, MD 21536</i>					
	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <i>atherosclerotic cardiovascular disease</i> Approximate Interval Between Onset and Death <i>years.</i>							
	23b. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <i>b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):</i>							
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Unknown				23d. Date of delivery Month Day Year	
Medical Certification: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Diabetes mellitus chronic renal failure, stage five</i>				23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred		
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)		
	29a. Certifier <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
	29b. Signature and title of certifier <i>Walter K. Noumann M.D.</i>				29c. License number <i>D 0025759</i>		29d. Date signed (Month, Day, Year) <i>April 16, 2007</i>	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Walter K. Noumann M.D. P.O. Box 247 Accident MD 21520</i>							
State Registrar	31. Date filed (Month, Day, Year) <i>APR - 9 2007</i>		32. Registrar's Signature <i>Susan A. Jones</i>					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2007 12235

1 - For
State
Registrar

Physician
/Medical
Examiner

Funeral
Director

Important: If item 27 is marked other than "natural", or items 23a or 28c-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28c-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

1. Decedent's Name (First, Middle, Last)							2. Date of Death Month Day Year			3. Time of Death	
Debby Diane Guessford							APRIL 5 2007			5:13 PM	
4a. Facility Name (If not institution, give street and number) Washington County Hospital							4b. City, Town, or Location of Death Hagerstown			4c. County of Death Washington	
5. Social Security Number 218-68-3865		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 51 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) OCT 19, 1955	9. Birthplace (State or Foreign Country) West Virginia				
10a. State MD 10b. County Washington							10c. City, Town or Location Maughansville			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number 13852 Greenfield Ave.				10f. Zip Code 21767			10g. Citizen of What Country? USA				
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 2 Technician			16b. Kind of Business/Industry Labratory				
17. Father's Name (First, Middle, Last) Felix Poling							18. Mother's Name (First, Middle, Maiden Surname) Wandalee Calhoun				
19a. Informant's Name/Relationship (Type, Print) Earl Guessford				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) PO Box 340, Maughansville, MD 21767							
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Olivet Cemetery			Date 4/10/07	20c. Location - City or Town, State Moorefield, WV			
21. Signature of Funeral Service Licensee Brian L Smith				22. Name and Address of Facility Fraley Funeral Home, LLC 145 N. Main St, Moorefield, WV							

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		23b. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Coronary Artery Disease				Approximate Interval Between Onset and Death		
23c. If female: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome pf pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown <input type="checkbox"/> Other (Specify)				23d. Date of delivery Month Day Year		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred			
		28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29c. License number DO60396				29d. Date signed (Month, Day, Year) 04/06/07		
29b. Signature and title of certifier Jane Smith								
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) FARID - MUNSHEED								
31. Date filed (Month, Day, Year) APRIL 17 2007		32. Registrar's Signature Leanne D. Spaul				33. Location (Street and Number or Rural Route Number, City or Town, State) Hagerstown, MD 21740		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

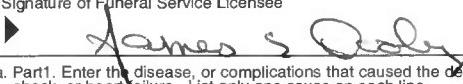
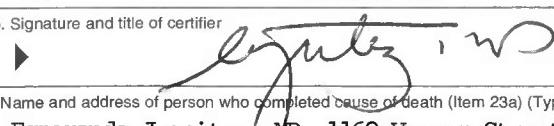
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2007 12236

1- For State Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Anastasia Gonzalez					2. Date of Death Month March Day 31 Year 2007	3. Time of Death 9:25 a M		
	4a. Facility Name (If not institution, give street and number) Sacred Heart Home					4b. City, Town, or Location of Death Hyattsville	4c. County of Death Prince George's		
Funeral Director	5. Social Security Number 078-28-0974	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 100 Yrs.	If Under 1 Year Months 0 Days 0	If Under 24 Hrs. Hours 0 Min. 0	8. Date of Birth (Month, Day, Year) December 16, 1906	9. Birthplace (State or Foreign Country) Cuba		
To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State Maryland 10b. County Prince George's 10c. City, Town or Location Hyattsville					10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
	10e. Street and Number 5805 Queens Chapel Road					10f. Zip Code 20782	10g. Citizen of What Country? USA		
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: 1906		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Specify: Cuban			14. Race - American Indian, Black, White, etc. Specify: Black		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 6		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Seamstress			16b. Kind of Business/Industry Clothing			
	17. Father's Name (First, Middle, Last) Genaro Zulueta					18. Mother's Name (First, Middle, Maiden Surname) Isidora Gonzalez			
	19a. Informant's Name/Relationship (Type, Print) Patricia Maria Alvarez/Friend			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2201 L. Street, NW, #306, Washington, DC 20037					
Physician /Medical Examiner	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Metropolitan Crematory			Date April 2, 2007	20c. Location - City or Town, State Alexandria, Virginia		
Medical Certification: To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee 					22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd, W, Silver Spring, MD 20901			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Hypertensive Cardiovascular Disease					Approximate Interval Between Onset and Death			
	b. Coronary Atherosclerotic Disease Due to (or as a consequence of): Renal Insufficiency								
	c. Due to (or as a consequence of): Degenerative Joint Disease								
	d. Due to (or as a consequence of): Anemia, Multifactorial								
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) Unknown			23d. Date of delivery Month 0 Day 0 Year 0000			
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Anemia, Multifactorial								
	23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown								
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year) April 2, 2007	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred			
	28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) At home					28f. Location (Street and Number or Rural Route Number, City or Town, State) 1160 Varnum Street, NE, Suite 8, Washington, DC 20017			
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					29b. Signature and title of certifier 			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Esmeraldo Juanitez, MD					29c. License number D51122	29d. Date signed (Month, Day, Year) April 2, 2007		
State Registrar	31. Date filed (Month, Day, Year) APR 03 2007		32. Registrar's Signature 						

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit slip.

3

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 12237

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last)						2. Date of Death Month Day Year	3. Time of Death
	John Thomas Goodwin, Jr.						Mar 31, 2007	
Funeral Director	4a. Facility Name (If not institution, give street and number)			4b. City, Town, or Location of Death			4c. County of Death	
	Calvert Memorial Hospital			Prince Frederick			Calvert	
To Be Completed by Funeral Director	5. Social Security Number		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) Yrs. 92	If Under 1 Year Months Days Hours Min.	8. Date of Birth (Month, Day, Year) May 28, 1914	9. Birthplace (State or Foreign Country) California	
	Usual Residence of Decedent		10a. State MD	10b. County Calvert	10c. City, Town or Location Huntingtown			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
10e. Street and Number 1441 Bidwell Lane				10f. Zip Code 20639		10g. Citizen of What Country? U.S.A.		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: 1942-1945		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: White			14. Race - American Indian, Black, White, etc. Specify: White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 5+		16b. Kind of Business/Industry Chemist			Research	
17. Father's Name (First, Middle, Last) John T. Goodwin, Sr.				18. Mother's Name (First, Middle, Maiden Surname) Zora Sarah Ponder				
19a. Informant's Name/Relationship (Type, Print) Nancy Bidne /Daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1441 Bidwell Lane Huntingtown, MD 20639				
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input checked="" type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) Metropolitan Crematory		20b. Place of Disposition (Name of cemetery, crematory or other place) Metropolitan Crematory			Date 04/02/07	20c. Location - City or Town, State Alexandria, VA		
21. Signature of Funeral Service Licensee ► Gladys A. Sewell		22. Name and Address of Facility Sewell Funeral Home 1451 Dares Beach Road Prince Frederick, MD 20678						
<p>23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.</p> <p>Immediate Cause (Final disease or condition resulting in death)</p> <p>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</p> <p>a. Due to (or as a consequence of): Acute renal failure</p> <p>b. Due to (or as a consequence of): Sepsis</p> <p>c. Due to (or as a consequence of): Dementia</p> <p>d. Due to (or as a consequence of): Deep vein thrombosis</p> <p>Approximate Interval Between Onset and Death</p>								
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome pf pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year			
<p>Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.</p> <p>23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown</p> <p>24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p>								
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred		
28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)						
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier ► D. Shew MD		29c. License number D 50270			29d. Date signed (Month, Day, Year) 4-2-07			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dhivya Shah 110, Hospt RD Prince Fred MD 20678								
31. Date filed (Month, Day, Year) APR 05 2007		32. Registrar's Signature Laura B. Spotts						

Baltimore, Maryland 21215-0036

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

51

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 12238

For
State
Registrar

1. Decedent's Name (First, Middle, Last)

Gladys L. Hunt

2. Date of Death
Month Day Year
April 8, 2007 12:22A M

3. Time of Death
12:22A M

4a. Facility Name (If not institution, give street and number)

Prince Georges Hospital

4b. City, Town, or Location of Death

Cheverly

4c. County of Death
Prince Georges

Physician
/Medical
Examiner

Funeral
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)
226-50-5457 1 M 2 F 94 Yrs.

If Under 1 Year
Months Days Hours Min.

8. Date of Birth
(Month, Day, Year)
Oct. 29, 1912

9. Birthplace (State or Foreign Country)
West Virginia

Usual Residence of Decedent

10a. State Md. 10b. County PG 10c. City, Town or Location Suitland

10d. Inside City Limits
1 Yes 2 No

10e. Street and Number

5101 Dianna Drive 10f. Zip Code 20746 10g. Citizen of What Country?
United States

11. Marital Status

1 Never Married 2 Married
3 Widowed 4 Divorced

12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 Yes 2 No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12) 12 College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

Domestic

16b. Kind of Business/Industry

Private

17. Father's Name (First, Middle, Last)

Israel Lee

18. Mother's Name (First, Middle, Maiden Surname)

Mollie Unknown

19a. Informant's Name/Relationship (Type, Print)

Shirley L. Jackson/daughter 5101 Dianna Drive

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Suitland, Md. 20746

Date

20c. Location - City or Town, State

Clinton, Md.

20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Resurrection Cem. 4/16/07

21. Signature of Funeral Service Licensee

Jane Edwards 22. Name and Address of Facility Hodges & Edwards F.H.
3910 Silver Hill Rd., Suitland, Md. 20746

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Immediate Cause (Final disease or condition resulting in death)

a. FATAL CARDIAC ARRHYTHMIA
Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

IF FEMALE:
23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No
9 Unknown

23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 3 Ectopic pregnancy
4 Pregnant at time of death 5 Other (specify)
9 Unknown

23d. Date of delivery
Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?
1 Yes 2 No 3 Probably 4 Unknown

25. Was case referred to medical examiner?

1 Yes 2 No

Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)

27. Manner of Death

1 Natural 5 Pending investigation
2 Accident 6 Could not be determined
3 Suicide
4 Homicide

28a. Date of Injury (Month, Day, Year) 28b. Time of Injury M 28c. Injury at Work?
1 Yes 2 No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier
(Check only one)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

D63056

29d. Date signed (Month, Day, Year)

4-8-2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR ANGELA LEE 3001 HOSPITAL DR

CHEVERLY, MD 20785

31. Date filed (Month, Day, Year)

APR 17 2007

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

12239

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Dexter Henderson							2. Date of Death Month Day Year April 5, 2007	3. Time of Death 2:01 P M
	4a. Facility Name (If not institution, give street and number) Prince Georges Hospital			4b. City, Town, or Location of Death Cheverly			4c. County of Death Prince Georges		
Funeral Director	5. Social Security Number 579-80-0480	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 42 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	Hours	Min.	8. Date of Birth (Month, Day, Year) Nov. 26, 1964	9. Birthplace (State or Foreign Country) Wash., DC
Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State Md.	10b. County PG	10c. City, Town or Location Bowie						10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
	10e. Street and Number 10305 Fox Lake Drive				10f. Zip Code 20715			10g. Citizen of What Country? United States	
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: 1968			13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: Black			14. Race - American Indian, Black, White, etc. Specify: Black	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Construction			16b. Kind of Business/Industry Private		
	17. Father's Name (First, Middle, Last) Leroy Henderson		18. Mother's Name (First, Middle, Maiden Surname) Martha Taylor						
	19a. Informant's Name/Relationship (Type, Print) Martha Henderson/mother		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Cameron Grove Blvd. Upper Marlboro, Md.						
Physician /Medical Examiner	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) Harmony Mem. Park		20b. Place of Disposition (Name of cemetery, crematory or other place) Harmony Mem. Park			Date 4/14/07	20c. Location - City or Town, State Landover, Md.		
	21. Signature of Funeral Service Licensee Janice Edwards		22. Name and Address of Facility Hodges & Edwards F.H. 3910 Silver Hill Rd., Suitland, Md. 20746						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Shock, or heart failure. List only one cause on each line.									
Approximate Interval Between Onset and Death									
Immediate Cause (Final disease or condition resulting in death)									
Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last									
<p>a. Fatal Cardiac Arrhythmia Due to (or as a consequence of):</p> <p>b. Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. </p>									
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown						23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									
23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown									
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA		Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29b. Signature and title of certifier Steven L. Fish MD		29c. License number DC MD 8510		29d. Date signed (Month, Day, Year) 4/09/07					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr Steven Fish 50 Irving St. N.W. Veteran Medical Center Wash DC 20001									
31. Date filed (Month, Day, Year) APR 17 2007		32. Registrar's Signature Alice K. Franklin							

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transit

Permit Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified all.

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2007 12240

1 - For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Ann Mildred Heald						2. Date of Death Month Day Year March 30, 2007	3. Time of Death 5:25 a M	
	4a. Facility Name (If not institution, give street and number) 1800 Bollinger Road			4b. City, Town, or Location of Death Westminster			4c. County of Death Carroll		
Funeral Director	5. Social Security Number 213-60-3928	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 93 Yrs.	If Under 1 Year Months 0	If Under 24 Hrs. Hours 0	Min. 0	8. Date of Birth (Month, Day, Year) Nov 15 1913	9. Birthplace (State or Foreign Country) MD	
	Usual Residence of Decedent 10a. State MD 10b. County Carroll 10c. City, Town or Location Westminster						10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
To Be Completed by Funeral Director	10e. Street and Number 1800 Bollinger Road				10f. Zip Code 21157		10g. Citizen of What Country? USA		
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: White		14. Race - American Indian, Black, White, etc. Specify: White		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 2 Registered Nurse			16b. Kind of Business/Industry Medical		
	17. Father's Name (First, Middle, Last) John Kelling				18. Mother's Name (First, Middle, Maiden Surname) Helen Smith				
	19a. Informant's Name/Relationship (Type, Print) Margaret Heald/Daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1800 Bollinger Rd Westminster, MD 21157				
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) Druid Ridge Cem			20b. Place of Disposition (Name of cemetery, crematory or other place) Pitts Funeral Home and Chapel, P.A.		Date 4/07/2007	20c. Location - City or Town, State Pikesville, MD		
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility 412 Washington Road Westminster, MD 21157				
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Congestive heart failure.								Approximate Interval Between Onset and Death long standing
	23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Heart failure Ovarian carcinoma Osteoporosis								
Medical Certification: To Be Completed by Physician/Medical Examiner	23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown				23d. Date of delivery Month Day Year				
	23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown								
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DDA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred		
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier 				
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Philip J. Rubansky MD				29c. License number D33599				
State Registrar	31. Date filed (Month, Day, Year) APR 02 2007		32. Registrar's Signature 		29d. Date signed (Month, Day, Year) 03-30-2007				

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit once.

Permit Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural" or items 23a or 28d show any injury or other traumatic event, the Medical Examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 1224

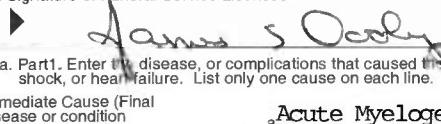
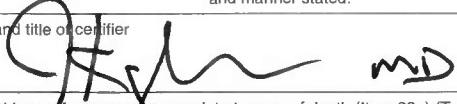
Physician /Medical Examiner	1- For State Registrar		
Funeral Director			

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural"; or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit

1. Decedent's Name (First, Middle, Last) Anita Bouffard Hayden			2. Date of Death Month March 31, 2007	3. Time of Death Year 12:40 PM
4a. Facility Name (If not institution, give street and number) 16001 Emory Lane			4b. City, Town, or Location of Death Rockville	
4c. County of Death Montgomery				
5. Social Security Number 036-03-0342		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 87 Yrs.	If Under 1 Year Months Days Hours Min. If Under 24 Hrs. Hours Min.
8. Date of Birth (Month, Day, Year) February 11, 1920		9. Birthplace (State or Foreign Country) Rhode Island		
10a. State Maryland			10b. County Montgomery	
10c. City, Town or Location Rockville			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number 16001 Emory Lane			10f. Zip Code 20853	10g. Citizen of What Country? USA
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: _____	13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: White	14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 9		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker	16b. Kind of Business/Industry Own Home	
17. Father's Name (First, Middle, Last) Nelson J. Bouffard			18. Mother's Name (First, Middle, Maiden Surname) Anna E. Macamber	
19a. Informant's Name/Relationship (Type, Print) Keith R. Hayden/ Son			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 16001 Emory Lane, Rockville, MD 20853	
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Gate of Heaven Cemetery	Date April 3, 2007	20c. Location - City or Town, State Silver Spring, Maryland
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd, W, Silver Spring, MD 20901		
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)			Approximate Interval Between Onset and Death	
a. Acute Myelogenous Leukemia Due to (or as a consequence of): _____				
b. Non-Hodgkins Lymphoma Due to (or as a consequence of): _____				
c. _____ Due to (or as a consequence of): _____				
d. _____ Due to (or as a consequence of): _____				
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				
23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown				
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No
		28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Describe how injury occurred
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier  Joseph Kaplan, M.D.		
29c. License number d35635		29d. Date signed (Month, Day, Year) April 2, 2007		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Joseph Kaplan, M.D. 9715 Medical Center Drive, #221, Gaithersburg, Maryland				
31. Date filed (Month, Day, Year) APR 03 2007		32. Registrar's Signature 		

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2007 12212

**1- For
State
Registrar**

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Ernestine Kimble Harrison						2. Date of Death Month Day Year March 31, 2007		3. Time of Death 10:00 p M							
	4a. Facility Name (If not institution, give street and number) Montgomery Hospice-Casey House			4b. City, Town, or Location of Death Rockville			4c. County of Death Montgomery									
Funeral Director	5. Social Security Number 239-48-6226			6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 74 Yrs.	If Under 1 Year Months Days Hours Min.	If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Year) Jan. 24, 1933		9. Birthplace (State or Foreign Country) North Carolina						
	Usual Residence of Decedent Maryland Montgomery			10a. State Silver Spring			10b. County USA			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						
To Be Completed by Funeral Director	10e. Street and Number 1204 Devere Drive				10f. Zip Code 20903		10g. Citizen of What Country? USA									
	11. Marital Status 1 <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc. 1 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: Specify: Black		14. Race - American Indian, Black, White, etc.									
Physician /Medical Examiner	15. Decedent's Education (Specify only highest grade completed)		Elementary/Secondary (0-12) College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)		16b. Kind of Business/Industry DC Government									
	17. Father's Name (First, Middle, Last) James Clarence Kimble				18. Mother's Name (First, Middle, Maiden Surname) Clemontine Carter											
Division or Vital Records, P.O. Box 68760, <small>permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.</small>	19a. Informant's Name/Relationship (Type, Print) Howard E. Harrison/ Husband			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1204 Devere Drive, Silver Spring, Maryland 20903			20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) Fort Lincoln Cemetery April 5, 2007				20b. Place of Disposition (Name of cemetery, crematory or other place) Francis J. Collins Funeral Home Inc.		Date 2007		20c. Location - City or Town, State Prentwood, Maryland	
	Medical Certification: To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility 500 University Blvd, W, Silver Spring, MD 20901				Approximate Interval Between Onset and Death						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)				a. Metastatic Melanoma Due to (or as a consequence of):				b. Due to (or as a consequence of):								
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				c. Due to (or as a consequence of):				d. Due to (or as a consequence of):								
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome pf pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) _____ 9 <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year												
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <hr/> <hr/>						23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown										
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) Hospice				24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Homicide 4 <input type="checkbox"/> Suicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred								
28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State)										
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier 				29c. License number H0058032		29d. Date signed (Month, Day, Year) April 1, 2007								
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Cynthia Williams, D.O. 6001 Muncaster Mill Road, Rockville, MD 20855						31. Date filed (Month, Day, Year) APR 03 2007										
32. Registrar's Signature 						33. Date of Birth (Month, Day, Year) Jan. 24, 1933										

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

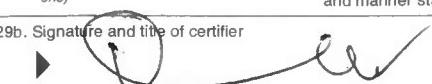
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 12213

1- For State Registrar

Physician / Medical Examiner	1. Decedent's Name (First, Middle, Last) Barbara Huff					2. Date of Death Month 03 Day 29 Year 07	3. Time of Death 0920 M		
	4a. Facility Name (If not institution, give street and number) WMHS Braddock Campus			4b. City, Town, or Location of Death Cumberland		4c. County of Death Allegany			
Funeral Director	5. Social Security Number 235-60-5880	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 69 Yrs.	If Under 1 Year Months Days Hours Min.	8. Date of Birth (Month, Day, Year) Sept. 3, 1937	9. Birthplace (State or Foreign Country) West Virginia			
To Be Completed by Funeral Director	10a. State WV		10b. County Mineral	10c. City, Town or Location Ridgeley			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
	10e. Street and Number 31 Second Avenue			10f. Zip Code 26753		10g. Citizen of What Country? U.S.A.			
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Specify Yes or No) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 2		College (1-4 or 5+) 2	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker			16b. Kind of Business/Industry Home		
	17. Father's Name (First, Middle, Last) J. Clarence Chidester				18. Mother's Name (First, Middle, Maiden Surname) Virginia Lewis				
	19a. Informant's Name/Relationship (Type, Print) Fred T. Huff / Husband			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 323, Ridgeley, WV 26753					
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) Fort Ashby Cemetery			20b. Place of Disposition (Name of cemetery, crematory or other place)	Date 04/02/2007	20c. Location - City or Town, State Fort Ashby, WV			
	21. Signature of Funeral Service Licensee 			22. Name and Address of Facility Upchurch Funeral Home, P.A. 202 Greene Street, Cumberland, MD 21502					
Physician / Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							Approximate Interval Between Onset and Death NOV 2002	
	<p>a. Due to (or as a consequence of): METASTATIC COLORECTAL CARCINOMA</p> <p>b. Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. Due to (or as a consequence of):</p>								
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown			23c. If yes, outcome pf pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) 9 Unknown			23d. Date of delivery Month Day Year		
Medical Certification: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
								24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide			28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred		
				28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.			29b. Signature and title of certifier 					
				29c. License number D23371			29d. Date signed (Month, Day, Year) MARCH 29, 2007		
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Gamar Zaman M.D., 625 Kent Avenue, Cumberland, MD 21502								
State Registrar	31. Date filed (Month, Day, Year) APR 02 2007		32. Registrar's Signature 						

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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725

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007

12244

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Dolores Jane Howerton					2. Date of Death Month Day Year March 31 2007	3. Time of Death 5:20 AM			
	4a. Facility Name (If not institution, give street and number) Calvert Memorial Hospital			4b. City, Town, or Location of Death Prince Frederick		4c. County of Death Calvert				
Funeral Director	5. Social Security Number 076-20-8259	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 78 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) March 7 1929	9. Birthplace (State or Foreign Country) Washington DC			
	Usual Residence of Decedent 10a. State Maryland			10b. County Calvert			10c. City, Town or Location St. Leonard		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
To Be Completed by Funeral Director	10e. Street and Number 2140 Timeless Drive			10f. Zip Code 20685		10g. Citizen of What Country? United States				
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: white			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 2			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) homekaer			16b. Kind of Business/Industry own home			
	17. Father's Name (First, Middle, Last) Ashton Bard Nixon				18. Mother's Name (First, Middle, Maiden Surname) Ananetta Melton					
	19a. Informant's Name/Relationship (Type, Print) Donald Eugene Howerton - husband			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2140 Timeless Dr. St. Leonard, MD 20685						
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Maryland Veterans Cemetery			Date April 5 2007	20c. Location - City or Town, State Cheltenham Maryland		
	21. Signature of Funeral Service Licensee 			22. Name and Address of Facility Rausch Funeral Home PA 4405 Broomes Is. Rd. Port Republic MD 20676						
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Pneumonia								Approximate Interval Between Onset and Death	
	b. Due to (or as a consequence of): Chronic Obstructive Pulmonary Disease									
	c. Due to (or as a consequence of): Hypertension									
	d. Due to (or as a consequence of):									
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown <input type="checkbox"/> Other (specify) _____			23d. Date of delivery Month Day Year				
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23e. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
									24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA		Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		26. Place of Death (Check only one)			
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred	
	28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)								28f. Location (Street and Number or Rural Route Number, City or Town, State)	
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
	29b. Signature and title of certifier 				29c. License number 00061947			29d. Date signed (Month, Day, Year) 3/31/07		
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M. Mathur MD Prince Frederick MD 20678									
	31. Date filed (Month, Day, Year) APR 02 2007									
Division or Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	32. Registrar's Signature 									
State Registrar	ORIGINAL									

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

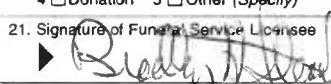
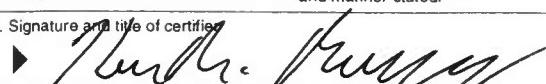
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2007 12245

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Janet Faye Hinebaugh							2. Date of Death Month Day Year April 4, 2007	3. Time of Death 3:32 P M
	4a. Facility Name (If not institution, give street and number) 1176 Crellin-Underwood Road			4b. City, Town, or Location of Death Oakland			4c. County of Death Garrett		
Funeral Director	5. Social Security Number 232-66-1495		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 64 Yrs.	If Under 1 Year Months Days Hours Min.	8. Date of Birth (Month, Day, Year) June 13, 1942		9. Birthplace (State or Foreign Country) West Virginia	
To Be Completed by Funeral Director	10a. State MD		10b. County Garrett		10c. City, Town or Location Oakland			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	10e. Street and Number 1176 Crellin-Underwood Road			10f. Zip Code 21550			10g. Citizen of What Country? USA		
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Operating Room Technician			16b. Kind of Business/Industry Hospital		
	17. Father's Name (First, Middle, Last) Hubert ----- Smith				18. Mother's Name (First, Middle, Maiden Surname) Iola Aslee Reckart				
	19a. Informant's Name/Relationship (Type, Print) Todd R. Hinebaugh/ Son				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 124 Crellin St., Oakland, Maryland 21550				
Physician /Medical Examiner	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Ashby Cemetery		Date 4/9/07	20c. Location - City or Town, State Oakland, Maryland		
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Stewart Funeral Home 32 S. Second St. Oakland, MD 21550				
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Arteriosclerotic Cardiovascular Disease Due to (or as a consequence of): Years								
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Arteriosclerotic Cardiovascular Disease Due to (or as a consequence of): Years								
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown								
	23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown								
	23d. Date of delivery Month Day Year								
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								
	23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown								
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No								
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
	Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)								
	26. Place of Death (Check only one)								
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined								
	28a. Date of Injury (Month, Day, Year) M 28b. Time of injury 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No								
	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No								
	28d. Describe how injury occurred								
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)								
	28f. Location (Street and Number or Rural Route Number, City or Town, State)								
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
	29b. Signature and title of certifier 								
	29c. License number D0061801								
	29d. Date signed (Month, Day, Year) 4/6/07								
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Kenneth R. Buczynski, MD 311 N. Fourth St., Oakland, Maryland 21550								
	31. Date filed (Month, Day, Year) APR - 6 2007		32. Registrar's Signature 						

Baltimore, Maryland 21215-0036

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached or used as the burial transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2007 12246

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) DONALD RAY HAYES							2. Date of Death Month March Day 31 Year 2007	3. Time of Death 03:52 M	
	4a. Facility Name (If not institution, give street and number) Washington County Hospital			4b. City, Town, or Location of Death Hagerstown			4c. County of Death Washington			
Funeral Director	5. Social Security Number 218-44-4780	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 59 Yrs.	If Under 1 Year Months 0	If Under 24 Hrs. Days 0	Hours 0	Min. 0	8. Date of Birth (Month, Day, Year) July 13, 1947	9. Birthplace (State or Foreign Country) Maryland	
Usual Residence of Decedent 10a. State Maryland 10b. County Washington 10c. City, Town or Location Hagerstown 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No										
10e. Street and Number 17 Fourth Street					10f. Zip Code 21740			10g. Citizen of What Country? United States		
To Be Completed by Funeral Director	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: ✓		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: White			14. Race - American Indian, Black, White, etc. Specify: White		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 0 bio-engineer		16b. Kind of Business/Industry Hospital					
	17. Father's Name (First, Middle, Last) Clarence Hayes					18. Mother's Name (First, Middle, Maiden Surname) Catherine Jones				
	19a. Informant's Name/Relationship (Type, Print) Lisa Washington daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 18509 Manassas Drive, Hagerstown, Maryland 21740					
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) Greenlawn Mem. Park		20b. Place of Disposition (Name of cemetery, crematory or other place) Greenlawn Mem. Park		Date 4/4/07	20c. Location - City or Town, State Williamsport, Maryland				
	21. Signature of Funeral Service Licensee Fred L. Vestal		22. Name and Address of Facility Minnich Funeral Home 415 E. Wilson Blvd., Hagerstown, Maryland 21740							
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) syncope Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last acute gastrointestinal bleed gastric ulcer alcohol abuse								Approximate Interval Between Onset and Death 3 days 30 days 730 years	
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome pf pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown		3 <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Other (Specify) 0		23d. Date of delivery Month Day Year			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. hypertension bipolar disorder										23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown 0
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA		Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) 0		23f. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown 0			
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year) 0		28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 0	28d. Describe how injury occurred			
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 0		28f. Location (Street and Number or Rural Route Number, City or Town, State) 0					
	29b. Signature and title of certifier Stephanie Brown MD		29c. License number DO053697		29d. Date signed (Month, Day, Year) 4/3/2007					
	31. Date filed (Month, Day, Year) APR 04 2007		32. Registrar's Signature Stephanie Brown							

ORIGINAL

Division or Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 12247

1- For State Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>Vincent Cardinal Henry</i>				2. Date of Death Month Day Year April 2 2007	3. Time of Death 06:22 AM		
	4a. Facility Name (If not institution, give street and number) Washington County Hospital		4b. City, Town, or Location of Death Hagerstown		4c. County of Death Washington			
Funeral Director	5. Social Security Number 223-23-9922	6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) 51 Yrs.	If Under 1 Year Months 0	If Under 24 Hrs. Days 0	8. Date of Birth (Month, Day, Year) April 13 1955	9. Birthplace (State or Foreign Country) Jamaica	
	Usual Residence of Decedent Maryland Washington		10c. City, Town or Location Hagerstown				10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
To Be Completed by Funeral Director	10e. Street and Number 43 Avalon Avenue			10f. Zip Code 21740		10g. Citizen of What Country? USA		
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Fork Lift Operator		16b. Kind of Business/Industry Warehouse			
	17. Father's Name (First, Middle, Last) James Henry			18. Mother's Name (First, Middle, Maiden Surname) Lucille Mae unknown				
	19a. Informant's Name/Relationship (Type. Print) LaEista Henry - Daughter			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 43 Avalon Avenue, Hagerstown, Maryland 21740				
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Greenlawn Mem. Park		Date 4/6/07	20c. Location - City or Town, State Williamsport, Maryland		
	21. Signature of Funeral Service Licensee 							
	22. Name and Address of Facility Minnich Funeral Home 415 E. Wilson Blvd. Hagerstown, Md. 21740							
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Ventricular Fibrillation Approximate Interval Between Onset and Death							
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Hypertension Diabetes							
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome pf pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown				23d. Date of delivery Month Day Year	
Medical Certification: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Hyperlipidemia							
	23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown							
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No					
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year) M	28b. Time of Injury M	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred		
			28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 			28f. Location (Street and Number or Rural Route Number, City or Town, State) 		
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician 2 <input type="checkbox"/> Medical Examiner		To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
	29b. Signature and title of certifier 		29c. License number DO057285		29d. Date signed (Month, Day, Year) 4/12/2007			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Cinaranraj Kailpillai 24 N. Walnut St. #102, Hagerstown, MD, 21740							
State Registrar	31. Date filed (Month, Day, Year) APR 04 2007		32. Registrar's Signature 					

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

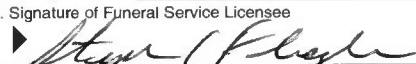
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2007 12243

1- For State Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Hayward Curtis Hoxter							2. Date of Death Month Month Day Year MARCH 20 2007			3. Time of Death 1135 AM																																													
	4a. Facility Name (If not institution, give street and number) MEMORIAL HOSPITAL @ EASTON			4b. City, Town, or Location of Death EASTON				4c. County of Death TALBOT																																																
Funeral Director	5. Social Security Number 072-48-5051		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) 51 Yrs.	If Under 1 Year Months 0	If Under 24 Hrs. Days 0	Hours 0	Min. 0	8. Date of Birth (Month, Day, Year) May 15 1955	9. Birthplace (State or Foreign Country) New York																																														
	10a. State Maryland		10b. County Caroline	10c. City, Town or Location Ridgely						10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No																																														
To Be Completed by Funeral Director	10e. Street and Number 403 Strawberry Court				10f. Zip Code 21660				10g. Citizen of What Country? U.S.A.																																															
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: Black																																															
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) laborer		16b. Kind of Business/Industry restaurant industry																																																		
	17. Father's Name (First, Middle, Last) Joseph Hayward Hoxter					18. Mother's Name (First, Middle, Maiden Surname) Callie Mae Williams																																																		
	19a. Informant's Name/Relationship (Type, Print) Callie M. Hoxter/ mother			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 604 Strawberry Court; Ridgely, Maryland 21660																																																				
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) New Union Cemetery			Date 03/28/2007	20c. Location - City or Town, State Goldsboro, Maryland																																																
	21. Signature of Funeral Service Licensee 			22. Name and Address of Facility Fleegle and Helfenbein Funeral Home, PA PO Box 160; Greensboro, Maryland 21639																																																				
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last											Approximate Interval Between Onset and Death years																																												
	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 10%;">a.</td> <td colspan="10">Due to (or as a consequence of): atherosclerotic Heart disease</td> </tr> <tr> <td>b.</td> <td colspan="10">Due to (or as a consequence of): End stage kidney disease</td> </tr> <tr> <td>c.</td> <td colspan="10">Due to (or as a consequence of): anemia</td> </tr> <tr> <td>d.</td> <td colspan="10"></td> </tr> </table>											a.	Due to (or as a consequence of): atherosclerotic Heart disease										b.	Due to (or as a consequence of): End stage kidney disease										c.	Due to (or as a consequence of): anemia										d.											
a.	Due to (or as a consequence of): atherosclerotic Heart disease																																																							
b.	Due to (or as a consequence of): End stage kidney disease																																																							
c.	Due to (or as a consequence of): anemia																																																							
d.																																																								
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown			23c. If yes, outcome pf pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify)						23d. Date of delivery Month Day Year																																														
Medical Certification: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. complete heart block											23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown																																												
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)																																																				
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide			28a. Date of Injury (Month, Day, Year) M		28b. Time of Injury M	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred																																																
	5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined			28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State)																																														
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.			29c. License number D 0046020						29d. Date signed (Month, Day, Year) 3/28/07																																														
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ali Syed, MD 505ADutchman's Lane; Easton, MD 21601																																																							
State Registrar	31. Date filed (Month, Day, Year) MAR 23 2007			32. Registrar's Signature 																																																				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 12249

1 - For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Annie Hunter						2. Date of Death Month 03 Day 31 Year 07	3. Time of Death 2113 M
	4a. Facility Name (If not institution, give street and number) WMHS Braddock Campus			4b. City, Town, or Location of Death Cumberland			4c. County of Death Allegany	
Funeral Director	5. Social Security Number 218-60-0338	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) Yrs. 86	If Under 1 Year Months 86	If Under 24 Hrs. Hours 0	Min. 0	8. Date of Birth (Month, Day, Year) June 18, 1920	9. Birthplace (State or Foreign Country) Scotland
	Usual Residence of Decedent Maryland Allegany			10c. City, Town or Location Cumberland				10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No
To Be Completed by Funeral Director	10e. Street and Number 901 Seton Drive			10f. Zip Code 21502			10g. Citizen of What Country? U.S.A.	
Physician /Medical Examiner	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: Specify:			14. Race - American Indian, Black, White, etc. White
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+)		16b. Kind of Business/Industry Homemaker			Home
	17. Father's Name (First, Middle, Last) Thomas Currie Gilmour		18. Mother's Name (First, Middle, Maiden Surname) Jean Speirs					
	19a. Informant's Name/Relationship (Type, Print) Janet Nolan - Daughter		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 935 Pine Crest Drive C-5, Cumberland, Maryland, 21502					
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) Scarpelli Funeral Home P.A. Crematory		20b. Place of Disposition (Name of cemetery, crematory or other place) Scarpelli Funeral Home P.A. Crematory		Date April 02, 2007	20c. Location - City or Town, State Cresaptown, Maryland		
	21. Signature of Funeral Service Licensee ▶ JES McIke		22. Name and Address of Facility Eichhorn-McKenzie Funeral Home P.A.		8 East Main Street, Lonaconing, Maryland 21539			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		23b. Due to (or as a consequence of): a. Respiratory Failure		Approximate Interval Between Onset and Death 8 days.			
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		23c. Due to (or as a consequence of): b. Severe Chronic Obstructive Pulmonary Disease		Years. years.			
	23d. Date of delivery Month Day Year		23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown					
	23f. If female: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome pf pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year			
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CONGESTIVE Heart Failure Diabetes mellitus		23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown					
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year) 28a. Date of Injury (Month, Day Year)		28b. Time of Injury M M	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred	
	28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)					
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29c. License number D25638		29d. Date signed (Month, Day, Year) April 2, 2007			
	29b. Signature and title of certifier ▶ S. Chang MD		29c. License number D25638		29d. Date signed (Month, Day, Year) April 2, 2007			
	31. Name and address of person who completed cause of death (Item 23a) (Type, Print) SATURNIAH CHANG MD 4 Broadway Frostburg Maryland 21532		32. Registrar's Signature ▶ S. Chang MD					
State Registrar	31. Date filed (Month, Day, Year) APR - 4 2007		32. Registrar's Signature ▶ S. Chang MD					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend Item 23a per dr., 866, 02/17/07 and

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2007 12250

1- For State Registrar

Physician /Medical Examiner		1. Decedent's Name (First, Middle, Last) LINDA D. HOVERMALE										2. Date of Death Month April Day 7 Year 2007		3. Time of Death 7:19 AM	
Funeral Director		4a. Facility Name (If not institution, give street and number) UNIVERSITY OF MARYLAND MEDICAL CENTER				4b. City, Town, or Location of Death BALTIMORE				4c. County of Death NIA					
To Be Completed by Funeral Director		5. Social Security Number 235-84-5126		6. Sex 1 □ M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 57 Yrs.		If Under 1 Year Months 		If Under 24 Hrs. Hours 		8. Date of Birth (Month, Day, Year) Jan. 31, 1950		9. Birthplace (State or Foreign Country) Berkeley Springs	
To Be Completed by Physician/Medical Examiner		10a. State WV		10b. County Morgan		10c. City, Town or Location Berkeley Springs						10d. Inside City Limits 1 □ Yes 2 <input checked="" type="checkbox"/> No			
To Be Completed by Physician/Medical Examiner		10e. Street and Number 1461 FAIRVIEW Dr.				10f. Zip Code 25411				10g. Citizen of What Country? USA					
To Be Completed by Physician/Medical Examiner		11. Marital Status 1 □ Never Married 2 <input checked="" type="checkbox"/> Married 3 □ Widowed 4 <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: 		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 □ Yes 2 <input checked="" type="checkbox"/> No Specify: White		14. Race - American Indian, Black, White, etc. Specify: White							
To Be Completed by Physician/Medical Examiner		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) administrative, assistant restaurant				16b. Kind of Business/Industry 					
To Be Completed by Physician/Medical Examiner		17. Father's Name (First, Middle, Last) David L. Hovermale				18. Mother's Name (First, Middle, Maiden Surname) Julia Spring									
To Be Completed by Physician/Medical Examiner		19a. Informant's Name/Relationship (Type, Print) Michelle Bubrman daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 502 Cleveland Ave, Waynesboro, PA 17268									
To Be Completed by Physician/Medical Examiner		20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Wesley Chapel Cemetery				Date 4-11-07	20c. Location - City or Town, State Cross Junction, VA				
To Be Completed by Physician/Medical Examiner		21. Signature of Funeral Service Licensee John Anderson				22. Name and Address of Facility Hunter - Anderson Funeral Home 365 S. Green St., Berkeley Springs, WV 25411									
To Be Completed by Physician/Medical Examiner		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Arterial Embolization Approximate Interval Between Onset and Death ANOXIC BRAIN INJURY													
To Be Completed by Physician/Medical Examiner		23b. Due to (or as a consequence of): a. Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):													
To Be Completed by Physician/Medical Examiner		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 <input checked="" type="checkbox"/> No 9 □ Unknown		23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify)				23d. Date of delivery Month Day Year							
To Be Completed by Physician/Medical Examiner		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.													
To Be Completed by Physician/Medical Examiner		23e. Did tobacco use contribute to the cause of death? 1 □ Yes 2 □ No 3 □ Probably 4 <input checked="" type="checkbox"/> Unknown													
To Be Completed by Physician/Medical Examiner		23f. Was an autopsy performed? 1 □ Yes 2 <input checked="" type="checkbox"/> No													
To Be Completed by Physician/Medical Examiner		24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No													
To Be Completed by Physician/Medical Examiner		25. Was case referred to medical examiner? 1 □ Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 □ ER/Outpatient 3 □ DOA Other: 4 □ Nursing Home 5 □ Residence 6 □ Other (Specify)											
To Be Completed by Physician/Medical Examiner		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 □ Pending investigation 2 □ Accident 6 □ Could not be determined 3 □ Suicide 4 □ Homicide		28a. Date of Injury (Month, Day Year) 		28b. Time of Injury M		28c. Injury at Work? 1 □ Yes 2 □ No		28d. Describe how injury occurred					
To Be Completed by Physician/Medical Examiner		28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 						28f. Location (Street and Number or Rural Route Number, City or Town, State) 							
To Be Completed by Physician/Medical Examiner		29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.													
To Be Completed by Physician/Medical Examiner		29b. Signature and title of certifier A. DORSCH MD		29c. License number 17410				29d. Date signed (Month, Day, Year) APRIL 7, 2007							
To Be Completed by Physician/Medical Examiner		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ANDREW DORSCH 22 S GREENE STREET BALTIMORE MARYLAND 21201													
To Be Completed by Physician/Medical Examiner		31. Date filed (Month, Day, Year) APR 17 2007		32. Registrar's Signature John B. Anderson											

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 12251

1- For State Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) JAMES Davis JOHNSTON							2. Date of Death Month 03 Day 20 Year 2007	3. Time of Death 1835 M
	4a. Facility Name (If not institution, give street and number) WMHS-BRADDOCK CAMPUS				4b. City, Town, or Location of Death CUMBERLAND			4c. County of Death ALLEGANY	
Funeral Director	5. Social Security Number 181-18-8496	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 84 Yrs.	If Under 1 Year Months Days Hours Min.			8. Date of Birth (Month, Day, Year) 10-31-1922	9. Birthplace (State or Foreign Country) PA	
To Be Completed by Funeral Director	10a. State PA		10b. County Bedford	10c. City, Town or Location Hyndman				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
	10e. Street and Number 113 5th Ave.				10f. Zip Code 15545			10g. Citizen of What Country? USA	
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: 43-45	13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Rural Letter Carrier			16b. Kind of Business/Industry US Postal Service		
	17. Father's Name (First, Middle, Last) James Clair Johnston				18. Mother's Name (First, Middle, Maiden Surname) Irene Maude Leamer				
	19a. Informant's Name/Relationship (Type, Print) Agnes L. Johnston / Wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 113 5th Ave. PO Box 203 Hyndman, PA 15545				
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input checked="" type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) Hyndman Cemetery		20b. Place of Disposition (Name of cemetery, crematory or other place) Hyndman Cemetery		Date 3-24-2007	20c. Location - City or Town, State Hyndman, PA			
	21. Signature of Funeral Service Licensee Jimmy W. Hart				22. Name and Address of Facility Harvey H. Zeigler Funeral Home, 169 Clarence St., Hyndman, PA 15545				
Physician /Medical Examiner	23a. Part I Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Ischaemic CARDIOMYOPATHY								Approximate Interval Between Onset and Death 2 yrs
	23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown								
	23c. If yes, outcome pf pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown								
	23d. Date of delivery Month Day Year								
Medical Certification: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Lewy Body DEMENTIA Acute on Chronic Renal Failure								
	23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown								
	23f. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
	23g. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No								
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
	26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide								
	28a. Date of Injury (Month, Day Year) M								
	28b. Time of Injury 1□ Yes 2□ No								
	28c. Injury at Work? 1□ Yes 2□ No								
	28d. Describe how injury occurred								
	28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)								
	28f. Location (Street and Number or Rural Route Number, City or Town, State)								
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
	29b. Signature and title of certifier Gregg Donaldson M.D.								
	29c. License number D 42054								
	29d. Date signed (Month, Day, Year) March 20 2007								
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Gregg Donaldson M.D. - 912 Seton Drive, Cumberland, MD 21502								
State Registrar	31. Date filed (Month, Day, Year) MAR 22 2007		32. Registrar's Signature James W. Hart						

Baltimore, Maryland 21215-0036

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

(9)
I-V-A
N-O-B

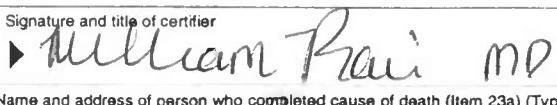
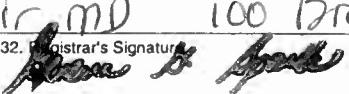
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 12252

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Edith Bloodsworth Jones							2. Date of Death Month April Day 02 Year 2007	3. Time of Death 21 ⁵⁰ P.M.		
	4a. Facility Name (If not institution, give street and number) DORCHESTER GENERAL HOSPITAL			4b. City, Town, or Location of Death CAMBRIDGE		4c. County of Death DORCHESTER					
Funeral Director	5. Social Security Number 219-07-7848	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 85 Yrs.	If Under 1-Year Months	If Under 24 Hrs. Days Hours Min.	8. Date of Birth (Month Day Year) 02/25/1922	9. Birthplace (State or Foreign Country) Maryland				
To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State Maryland 10b. County Dorchester 10c. City, Town or Location Cambridge				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No						
	10e. Street and Number 505 Edlon Park			10f. Zip Code 21613		10g. Citizen of What Country? USA					
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White					
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+) Group Leader			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Electronics			16b. Kind of Business/Industry				
	17. Father's Name (First, Middle, Last) Noble Andrew Bloodsworth				18. Mother's Name (First, Middle, Maiden Surname) Minnie McGlaughlin						
	19a. Informant's Name/Relationship (Type, Print) Janet Jones Todd/ Daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 505 Edlon Park, Cambridge, MD 21613						
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)	20b. Place of Disposition (Name of cemetery, crematory or other place) East New Market Cemetery			Date	20c. Location - City or Town, State 4/5/2007 East New Market, MD					
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Curran-Bromwell Funeral Home, P.A. 308 High St., Cambridge, MD 21613						
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death 5 days		
	<p>a. Due to (or as a consequence of): Peritonitis</p> <p>b. Due to (or as a consequence of): Perforated Diverticulitis</p> <p>c. Due to (or as a consequence of):</p> <p>d. Due to (or as a consequence of):</p>								Approximate Interval Between Onset and Death 5 days		
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown				23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____					23d. Date of delivery Month Day Year	
Medical Certification: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
									24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred				
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)								28f. Location (Street and Number or Rural Route Number, City or Town, State)		
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier  William Bair MD						
	29c. License number 043238				29d. Date signed (Month, Day, Year) April 2, 2007						
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) William Bair MD 100 Bramble St. Cambridge, MD 21613										
State Registrar	31. Date filed (Month Day Year) APR 04 2007		32. Registrar's Signature 								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

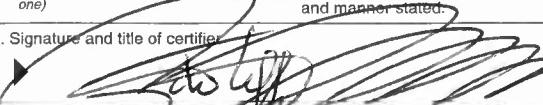
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2007 12253

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Donald Orlo King					2. Date of Death Month 3 Day 30 Year 2007	3. Time of Death 12:36 P.M.						
	4a. Facility Name (If not institution, give street and number) 4908 Pleasant Grove Road			4b. City, Town, or Location of Death Reisterstown		4c. County of Death Baltimore							
Funeral Director	5. Social Security Number 220-32-3138	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 83 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) 7/21/1923	9. Birthplace (State or Foreign Country) Maryland						
	Usual Residence of Decedent 10a. State MD 10b. County Baltimore			10c. City, Town or Location Reisterstown			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						
To Be Completed by Funeral Director	10e. Street and Number 4908 Pleasant Grove Road			10f. Zip Code 21136		10g. Citizen of What Country? United States							
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. White							
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Sales		16b. Kind of Business/Industry Agricultural Chemicals								
	17. Father's Name (First, Middle, Last) Wilmer Edwin King			18. Mother's Name (First, Middle, Maiden Surname) Clara Jeanette Ensor									
	19a. Informant's Name/Relationship (Type, Print) Violet L. King-Wife			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4908 Pleasant Grove Road Reisterstown, MD 21136									
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Pleasant Grove Cemet.		Date 4/4/2007	20c. Location - City or Town, State Reisterstown, Maryland						
	21. Signature of Funeral Service Licensee 			22. Name and Address of Facility M001490 Eline Funeral Home, 934 South Main Street Hampstead, Maryland 21074									
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Fundusma - Due to (or as a consequence of): Primary Hypertension. b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):							Approximate Interval Between Onset and Death					
	23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown			23c. If yes, outcome pf pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown <input type="checkbox"/> Other (specify) _____			23d. Date of delivery Month Day Year						
Medical Certification: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Coronary Artery Disease							23e. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown					
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				23f. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown					
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide			28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred			24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
				28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.												
	29b. Signature and title of certifier 			29c. License number 558489				29d. Date signed (Month, Day, Year) 4/2/2007					
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4500 Black Rock Road, Hampstead, MD 21074												
State Registrar	31. Date filed (Month, Day, Year) APR 02 2007			32. Registrar's Signature 									

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural"; or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division or Vital Records, P.O. Box 68760,

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 1225

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) WILLIAM EARL KINES, JR.						2. Date of Death Month MARCH	Day 22, 2007	3. Time of Death Year 10:50 A M
	4a. Facility Name (If not institution, give street and number) Beverly Living Center			4b. City, Town, or Location of Death Cumberland			4c. County of Death Allegany		
Funeral Director	5. Social Security Number 220-30-7916	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 72 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Hours	8. Date of Birth (Month, Day, Year) AUG. 4, 1934	9. Birthplace (State or Foreign Country) Maryland		
To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State WV 10b. County Mineral 10c. City, Town or Location Ridgeley						10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
	10e. Street and Number 141 Main Street			10f. Zip Code 26753			10g. Citizen of What Country? U.S.A.		
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 2 College (1-4 or 5+) 2		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Tire Builder			16b. Kind of Business/Industry Kelly-Springfield Tire Company			
	17. Father's Name (First, Middle, Last) William Earl Kines, Sr.				18. Mother's Name (First, Middle, Maiden Surname) Maude Matilda Smith				
	19a. Informant's Name/Relationship (Type, Print) Linda Kines / Wife			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 131, Ridgeley, WV 26753					
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Cumberland Crematory			Date 03/24/07	20c. Location - City or Town, State Cumberland, MD	
Physician /Medical Examiner	21. Signature of Funeral Service Licensee <i>Wendy A. Tepkeard</i>			22. Name and Address of Facility Upchurch Funeral Home, P.A. 202 Greene Street, Cumberland, MD 21502					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Carcinoma of Lung Approximate Interval Between Onset and Death 1 yr.								
	<p>a. Due to (or as a consequence of): Carcinoma of Lung</p> <p>b. Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. Due to (or as a consequence of):</p>								
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown			23c. If yes, outcome pf pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown <input type="checkbox"/> Other (specify) _____			23d. Date of delivery Month Day Year		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. _____ _____									
	23e. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown								
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide			28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred		
				28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)		
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.			29b. Signature and title of certifier <i>Sunil K. Gupta</i>					
				29c. License number D0033280			29d. Date signed (Month, Day, Year) March 23, 2007		
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SUNIL K. GUPTA MD - 625 Kent Ave, Cumberland, MD 21502			31. Date filed (Month, Day, Year) MAR 28 2007					
State Registrar	32. Registrar's Signature <i>Sunil K. Gupta</i>								

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
 Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Ryke Keeney

07-02474

UNK UNK

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2007 12255

Certificate of Death

Reg. No.

1- For State
Registrar

Physician/ Medical Examiner		1. Decedent's Name (First, Middle, Last) RYLEE KALYN KEENEY				2. Date of Death Month Day Year March 31, 2007	3. Time of Death 2001 hrs		
Funeral Director		4a. Facility Name (if not institution, give street and number) 21108 Boonsboro Mountain Rd.		4b. City, Town, or Location of Death Boonsboro		4c. County of Death Washington			
To Be Completed by Funeral Director		5. Social Security Number 214-31-7839	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 16 Yrs.	If Under 1 Year Months Days Hours Min	8. Date of Birth (MM/DD/YYYY) Dec. 23, 1990	9. Birthplace (State or Foreign Country) Maryland		
		10a. State Maryland	10b. County Frederick	10c. City, Town or Location Knoxville			10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
		10e. Street and Number 946 Hoffmaster Road			10f. Zip Code 21758	10g. Citizen of What Country? U.S.A.			
To Be Completed by Physician/Medical Examiner		11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married	12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No specify:	14. Race - American Indian, Black, White, etc. Specify: White				
		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Waitress	16b. Kind of Business/Industry Restaurant					
		17. Father's Name (First, Middle, Last) Rafe Wesley Keeney	18. Mother's Name (First, Middle, Maiden Surname) Kelly Elizabeth Weaver						
Physician /Medical Examiner		19a. Informant's Name/Relationship (Type, Print) Kelly E. Keeney / Mother	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 946 Hoffmaster Road, Knoxville, MD 21758						
		20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other Specify	20b. Place of Disposition (Name of cemetery, crematory or other place) Samples Manor Cem.	Date 4/5/07	20c. Location - City or Town, State Dargan, Maryland				
		21. Signature of Funeral Service Licensee 	22. Name and Address of Facility ROBERT E. DAILEY & SON FUNERAL HOMES, P.A. 1201 NORTH MARKET ST., FREDERICK, MD 21701						
		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Head Injuries Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. □ UNPENDED □ AMENDED	Approximate Interval Between Onset and Death						
		23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input checked="" type="checkbox"/> Unknown	23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown	23d. Date of delivery Month Day Year					
		23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown							
		24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No						
		25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	26 Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other: Scene						
		27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input checked="" type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide	28a. Date of Injury Mar 31, 2007	28b. Time of Injury 2050 hrs	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	28d. Describe how injury occurred Driver of auto which struck fixed object			
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Street	28f. Location (Street and Number or Rural Route Number, City or Town, State) 21108 Boonsboro Mountain Rd., Boonsboro, Md.					
		29a. Certifier 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
		29b. Signature and title of certifier 	29c. License number O.C.M.E.			29d. Date signed (Month, Day, Year) April 1, 2007			
		30. Name and address of person who completed cause of death (Item 23a) Patricia Aronica-Pollak MD. Assistant Medical Examiner	111 Penn Street, Baltimore, MD 21201						
State Registrar		31. Date filed (Month, Day, Year) APR 04 2007	32. Registrar's Signature 						

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transit

Baltimore, MD 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
 Important: If item 27 is marked other than "natural", or items 23a or 28a show any injury or other traumatic event, the Medical Examiner must be notified at once.

DHHM 17 Rev 1/2001
OCME 2006

ORIGINAL

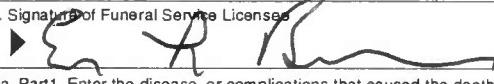
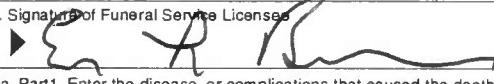
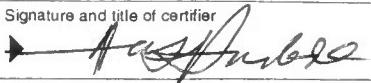
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2007 12256
Reg. No.

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Jack Carlton Kephart					2. Date of Death Month Day Year March 31 2007	3. Time of Death 8:50A M	
	4a. Facility Name (If not institution, give street and number) Western Maryland Hospital Center			4b. City, Town, or Location of Death Hagerstown		4c. County of Death Washington		
Funeral Director	5. Social Security Number 219-05-2337	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 88 Yrs.	If Under 1 Year Months Days Hours Min.	8. Date of Birth (Month, Day, Year) April 15 1918		9. Birthplace (State or Foreign Country) Maryland	
To Be Completed by Funeral Director	10a. State Maryland			10b. County Washington			10c. City, Town or Location Hagerstown	
	10e. Street and Number 1025 Columbia Road			10f. Zip Code 21742			10g. Citizen of What Country? U.S.A.	
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: 1945		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: White		14. Race - American Indian, Black, White, etc. White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) engineer		16b. Kind of Business/Industry Toy Manufacturing			
	17. Father's Name (First, Middle, Last) Carmen N. Kephart			18. Mother's Name (First, Middle, Maiden Surname) Henrietta Derr				
	19a. Informant's Name/Relationship (Type, Print) Lynda Byers / Daughter			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1147 Outer Drive Hagerstown Maryland 21742				
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) 			20b. Place of Disposition (Name of cemetery, crematory or other place) Rest Haven Cemetery	Date 4/5/2007	20c. Location - City or Town, State Hagerstown Maryland		
	21. Signature of Funeral Service Licensee 			22. Name and Address of Facility Rest Haven Funeral Chapel 1601 Pennsylvania Ave Hagerstown Maryland 21742				
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) metastatic prostate cancer Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last { a. Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. _____							Approximate Interval Between Onset and Death 2 years
Medical Certification: To Be Completed by Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown			23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Renal failure, chronic atrial fibrillation Anemia, chronic obstructive pulmonary disease Decubitus ulcers							23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred		
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)							
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
	29b. Signature and title of certifier 							
	29c. License number 027898							
	29d. Date signed (Month, Day, Year) April 4, 2007							
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Francisco Andrade, M.D.							
	31. Date filed (Month, Day, Year) APR 05 2007							
	32. Registrar's Signature 							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2007 12257

1- For State Register

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Arnold Floyd Kruse						2. Date of Death Month Day Year March 31, 2007	3. Time of Death 7:30 P M		
	4a. Facility Name (If not institution, give street and number) 1534 Dockside Drive			4b. City, Town, or Location of Death Frederick			4c. County of Death Frederick			
Funeral Director	5. Social Security Number 485-42-4929	6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) 69 Yrs.	If Under 1 Year Months 0	If Under 24 Hrs. Days 0	Hours 0	Min. 0	8. Date of Birth (Month, Day, Year) Oct 6, 1937	9. Birthplace (State or Foreign Country) Iowa	
To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State MD 10b. County Frederick 10c. City, Town or Location Frederick								10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	10e. Street and Number 1534 Dockside Drive			10f. Zip Code 21701			10g. Citizen of What Country? USA			
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Carpenter			16b. Kind of Business/Industry Construction			
	17. Father's Name (First, Middle, Last) Elmer Kruse				18. Mother's Name (First, Middle, Maiden Surname) Louise Loecke					
	19a. Informant's Name/Relationship (Type, Print) Brenda Kruse-McConville/daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1534 Dockside Drive Frederick, MD 21701					
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Chesapeake Crematory			Date 04/03/07	20c. Location - City or Town, State Beltsville, MD		
Physician /Medical Examiner	21. Signature of Funeral Service Licensee Beverly L. Heckrotte			22. Name and Address of Facility Going Home Cremation Service P.O. Box 784 M01251 Beverly L. Heckrotte, P.A. Clarksville, MD 21029						
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Rectal Cancer								Approximate Interval Between Onset and Death 10 M	
	Immediate Cause (Final disease or condition resulting in death) Rectal Cancer									
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last {									
	a. Due to (or as a consequence of): Rectal Cancer									
	b. Due to (or as a consequence of): 									
	c. Due to (or as a consequence of): 									
	d. Due to (or as a consequence of): 									
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 4 <input type="checkbox"/> Pregnant at time of death 9 <input type="checkbox"/> Unknown 3 <input type="checkbox"/> Ectopic pregnancy 5 <input type="checkbox"/> Other (specify)					23d. Date of delivery Month Day Year		
Medical Certification: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
									24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
									24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year) M		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
	5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State)	
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
	29b. Signature and title of certifier J. Eskander, M.D.		29c. License number D 48184			29d. Date signed (Month, Day, Year) 4/2/07				
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Elhamy Eskander, M.D. 501 W. 7th Street Suite 1A Frederick, MD 21701									
State Registrar	31. Date filed (Month, Day, Year) APR 03 2007		32. Registrar's Signature Elhamy Eskander							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2007 12258

1- For
State
Registrar

**Physician
/Medical
Examiner**

1. Decedent's Name (First, Middle, Last)
ROBERT LEE KROLL

2. Date of Death
Month Day Year
April 2 2007

3. Time of Death
1359 M

4a. Facility Name (If not institution, give street and number)
The Memorial Hospital

4b. City, Town, or Location of Death
Easton

4c. County of Death
Talbot

**Funeral
Director**

5. Social Security Number
216-42-4302

6. Sex
M

7. Age (In yrs. last birthday)
63 Yrs.

If Under 1 Year
Months Days Hours Min.
0 0 0 0

8. Date of Birth
(Month, Day, Year)
Nov. 2, 1943

9. Birthplace (State or Foreign Country)
Maryland

Usual Residence of Decedent

10a. State
MD

10b. County
Dorchester

10c. City, Town or Location
Federalsburg

10d. Inside City Limits
1 Yes 2 No

10e. Street and Number
**Lot 15
P.O. Box 331, Reliance Trailer Park**

10f. Zip Code
21632

10g. Citizen of What Country?
United States

11. Marital Status
1 Never Married 2 Married
3 Widowed 4 Divorced

12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No
If Yes, Give Year or Dates:
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 Yes 2 No Specify:
Specify: White

14. Race - American Indian, Black, White, etc.
Specify: **White**

15. Decedent's Education
(Specify only highest grade completed)
Elementary/Secondary (0-12) **12** College (1-4 or 5+) **College**

16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)
Paramedic for Baltimore City

16b. Kind of Business/Industry
Medical Care

17. Father's Name (First, Middle, Last)
Robert Lee Kroll, Sr.

18. Mother's Name (First, Middle, Maiden Surname)
Margaret Lewis Johnson

19a. Informant's Name/Relationship (Type, Print)
Rosie Bell/Companion

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
P.O. Box 331, Federalsburg, MD 21632

20a. Method of Disposition
1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify)
Unity-Washington Cem. 4/6/07

20b. Place of Disposition (Name of cemetery, crematory or other place)

Date

20c. Location - City or Town, State
Hurlock, Maryland

21. Signature of Funeral Service Licensee
Christine M. Coale

22. Name and Address of Facility
**Frampton Funeral Home, PA
Federalsburg, MD**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Immediate Cause (Final disease or condition resulting in death)
Hemoptysis

Approximate Interval Between Onset and Death
Hours

a. Due to (or as a consequence of):
Metastatic colon cancer

Years

b. Due to (or as a consequence of):
Underlying cause

c. Due to (or as a consequence of):
Underlying cause

d. Due to (or as a consequence of):
Underlying cause

IF FEMALE:
23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 9 Unknown

23c. If yes, outcome pf pregnancy
1 Live birth 2 Fetal death 3 Ectopic pregnancy
4 Pregnant at time of death 5 Other (specify)
9 Unknown

23d. Date of delivery
Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Liver cirrhosis

23e. Did tobacco use contribute to the cause of death?
1 Yes 2 No 3 Probably 4 Unknown

25. Was case referred to medical examiner?
1 Yes 2 No

26. Place of Death (Check only one)
Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)

27. Manner of Death
1 Natural 5 Pending investigation
2 Accident 6 Could not be determined
3 Suicide 7 Homicide
4 Homicide

28a. Date of Injury (Month, Day Year)
28b. Time of Injury
M 1 Yes 2 No

28c. Injury at Work?
1 Yes 2 No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier
(Check only one)
1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier
L Vaidyanathan MD

29c. License number
DO 57749

29d. Date signed (Month, Day, Year)
APRIL 3 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Dr. Lakshmi Vaidyanathan, 219 S. Washington St., Easton, Md. 21601

31. Date filed (Month, Day, Year)
APR 09 2007

32. Registrar's Signature
L Vaidyanathan

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a/c show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Important: If Item 27 is marked other than "natural", or items 23a or 28a/c show any injury or other traumatic event, the Medical Examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 12259

Baltimore, Maryland 21215-0036		Medical Certification: To Be Completed by Physician/Medical Examiner									
<p>Physician /Medical Examiner</p> <p>permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.</p> <p>Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.</p>		1. Decedent's Name (First, Middle, Last)				2. Date of Death		3. Time of Death			
		CHARLOTTE PATRICIA KERN				Month	Day	Year	11:10 A M		
<p>Funeral Director</p> <p>To Be Completed by Funeral Director</p>		4a. Facility Name (If not institution, give street and number)			4b. City, Town, or Location of Death			4c. County of Death			
		FREDERICK MEMORIAL HOSPITAL			FREDERICK			FREDERICK			
		5. Social Security Number		6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)		
		220-42-5706		1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	62 Yrs.	Months	Days	Hours	Min.	June 25 1944 Frederick, MD	
		Usual Residence of Decedent		10a. State		10b. County		10c. City, Town or Location			10d. Inside City Limits
				MD		Frederick		Frederick			1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No
		10e. Street and Number		2689 Cameron Way			10f. Zip Code			10g. Citizen of What Country?	
							21701			USA	
		11. Marital Status		12. Was Decedent Ever in U.S. Armed Forces?			13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)			14. Race - American Indian, Black, White, etc.	
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:			1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			Specify: White			
15. Decedent's Education (Specify only highest grade completed)		Elementary/Secondary (0-12)			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)			16b. Kind of Business/Industry			
					College (1-4 or 5+) 5 Teacher			North Frederick Elementary School			
17. Father's Name (First, Middle, Last)		Howard Eugene Werking			18. Mother's Name (First, Middle, Maiden Surname)			Ethel Patricia O'Hara			
19a. Informant's Name/Relationship (Type, Print)		Patricia D. Jarrell, Daughter			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)						
					2687 Cameron Way, Frederick, MD 21701						
20a. Method of Disposition		20b. Place of Disposition (Name of cemetery, crematory or other place)			Date		20c. Location - City or Town, State				
1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		Hagerstown Crematory			4/2/07		Hagerstown, MD				
21. Signature of Funeral Service Licensee ► Barbara A. Williams, Owner		22. Name and Address of Facility			John T. Williams Funeral Home			Approximate Interval Between Onset and Death			
					100 Petersville Road, Brunswick, MD 21716			YEARS			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.											
Immediate Cause (Final disease or condition resulting in death)											
a. AMYLOIDOSIS Due to (or as a consequence of):											
b. WALDENSTROM'S MACROGLOBULINEMIA Due to (or as a consequence of):											
c. _____ Due to (or as a consequence of):											
d. _____											
Approximate Interval Between Onset and Death											
YEARS											
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last											
IF FEMALE:		23c. If yes, outcome pf pregnancy			3 <input type="checkbox"/> Ectopic pregnancy			23d. Date of delivery			
23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown		1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 4 <input type="checkbox"/> Pregnant at time of death 9 <input type="checkbox"/> Unknown			5 <input type="checkbox"/> Other (specify) _____			Month Day Year			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										23e. Did tobacco use contribute to the cause of death?	
FND STAGE KIDNEY FAILURE ON DIALYSIS CACHEXIA										1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
25. Was case referred to medical examiner?		26. Place of Death (Check only one)									
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		Hospital: <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)									
27. Manner of Death		28a. Date of Injury (Month, Day Year)		28b. Time of Injury		28c. Injury at Work?		28d. Describe how injury occurred			
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		M		1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No							
28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)									
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.											
29b. Signature and title of certifier ► B. Roman, MD		29c. License number			29d. Date signed (Month, Day, Year)						
		D 0060764			04/01/2007						
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)											
BRIANSLAV ROMANIC, MD 172 THOMAS JOHNSON DR, FREDERICK MD											
31. Date filed (Month, Day, Year)		32. Registrar's Signature									
APR 03 2007		Brian Romanic									

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and

To the Hospital or Attendi-

10

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2007 12260

Reg. No.

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Orval Isadore Kitzmiller					2. Date of Death Month Day Year March 29, 2007	3. Time of Death 12:35A M	
	4a. Facility Name (If not institution, give street and number) 212 D. St.			4b. City, Town, or Location of Death Mt. Lake Park		4c. County of Death Garrett		
Funeral Director	5. Social Security Number 213-12-9783	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 94 Yrs.	If Under 1 Year Months 8/2/1912	If Under 24 Hrs. Hours 8/2/1912	8. Date of Birth (Month, Day, Year) 8/2/1912	9. Birthplace (State or Foreign Country) Maryland	
	10a. State MD		10b. County Garrett	10c. City, Town or Location Mountain Lake Park			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
To Be Completed by Funeral Director	10e. Street and Number 212 D. Street			10f. Zip Code 21550		10g. Citizen of What Country? USA		
Physician /Medical Examiner	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: 3rd			13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: White		14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 3rd			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Farmer			16b. Kind of Business/Industry Farming	
Medical Certification: To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) William Henry Kitzmiller				18. Mother's Name (First, Middle, Maiden Surname) Ada Snyder			
Physician /Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Mildred Kitzmiller/ Wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 121 D. St., Mt. Lake Park, MD 21550			
Medical Certification: To Be Completed by Physician/Medical Examiner	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) Burial			20b. Place of Disposition (Name of cemetery, crematory or other place) Pleasant Valley Cem.		Date 4/1/07	20c. Location - City or Town, State Oakland, Maryland	
Physician /Medical Examiner	21. Signature of Funeral Service Licensee Beverly Stump				22. Name and Address of Facility Stewart Funeral Home			
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Chronic Renal Failure				Approximate Interval Between Onset and Death 4 years			
Physician /Medical Examiner	23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown				23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) Unknown		23d. Date of delivery Month Day Year	
Physician /Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Cancer of esophagus, colon, prostate, lung				23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
Physician /Medical Examiner	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA			Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		
Physician /Medical Examiner	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year) MD	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred		
Physician /Medical Examiner	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) At home				28f. Location (Street and Number or Rural Route Number, City or Town, State) Oakland, MD 21550			
Physician /Medical Examiner	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29c. License number D27205			
Physician /Medical Examiner	29b. Signature and title of certifier Karl E. Schwalm, M.D.				29d. Date signed (Month, Day, Year) 03/29/2007			
Physician /Medical Examiner	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Karl E. Schwalm, M.D. 311 N Fourth Street Oakland, MD 21550				31. Date filed (Month, Day, Year) APR - 2 2007			
Physician /Medical Examiner	32. Registrar's Signature State Registrar				33. Date filed (Month, Day, Year) APR - 2 2007			

Baltimore, Maryland 21215-0036

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e if show any injury or other traumatic event, it is Medical Examiner, not Funeral Director, who should file.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Amended #18, nls,
03/15/07, Allegany Co.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amended #23a Line C, MLU Certificate of Death
03/26/07 Allegany Co.

Reg. No. 2007

12261

1- For State Registrar

Physician /Medical Examiner

Funeral Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

10

7/25

State Registrar

Physician /Medical Examiner		Louise Lavelle		2. Date of Death Month 3 Day 10 Year 2007	3. Time of Death 2140 M
Funeral Director		WMHS-Braddock Campus		4b. City, Town, or Location of Death Cumberland	
		5. Social Security Number 215-34-4451	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 71 Yrs.	8. Date of Birth (Month, Day, Year) APR. 26, 1935
		Usual Residence of Decedent 10a. State MD 10b. County ALLEGANY		10c. City, Town or Location CUMBERLAND	
		10e. Street and Number 10211 HILLCREST DRIVE		10f. Zip Code 21502	10g. Citizen of What Country? U.S.A.
		11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:	14. Race - American Indian, Black, White, etc. Specify: WHITE
		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) CASHIER	16b. Kind of Business/Industry GIANT FOOD CAFETERIA	
		17. Father's Name (First, Middle, Last) OWEN F. RICE		18. Mother's Name (First, Middle, Maiden Surname) NOLA VANAE- VANCE	
		19a. Informant's Name/Relationship (Type, Print) OWEN J. RICE / BROTHER		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 510 WELCH AVENUE, CUMBERLAND, MD 21502	
		20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) ZION MEMORIAL PARK	Date 03/15/2007
		21. Signature of Funeral Service Licensee ► Wendy O. Foxhach		20c. Location - City or Town, State CUMBERLAND, MD	
		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) { a. <u>CARDIO- PULMONARY ARREST</u> Due to (or as a consequence of): b. <u>CARDIOGENIC SHOCK</u> Due to (or as a consequence of): c. <u>Pericarditis</u> Due to (or as a consequence of): d. _____		Approximate Interval Between Onset and Death	
		23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome pf pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) _____	
		23d. Date of delivery Month Day Year		23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown	
		25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)	
		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Determined 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 28d. Describe how injury occurred	
		28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
		29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29c. License number D0063462	
		29b. Signature and title of certifier ► Podlesar		29d. Date signed (Month, Day, Year) 3/11/2007	
		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ALIDA PODLESAR WMHS 900 SETON DRIVE CUMBERLAND			
		31. Date filed (Month, Day, Year) MAR 15 2007	32. Registrar's Signature ► Lee B. Foxhach		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2007 12262
Reg. No.1- For
State
RegistrarPhysician
/Medical
ExaminerFuneral
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
 Important: If item 27 is marked other than "natural", or items 23a or 28e-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

1. Decedent's Name (First, Middle, Last) Ralph Frederick Lundregan		2. Date of Death Month Apr. Day 1 Year 2007	3. Time of Death 9:55 P M
4a. Facility Name (If not institution, give street and number) 7307 Countryside Dr.		4b. City, Town, or Location of Death Middletown	
4c. County of Death Frederick		8. Date of Birth (Month, Day, Year) Jan. 2, 1933	
5. Social Security Number 214-28-4873		6. Sex 1 XM 2 F	7. Age (In yrs. last birthday) 74 Yrs.
8. If Under 1 Year Months 0 Days 0		9. If Under 24 Hrs. Hours 0 Min. 0	
10a. Usual Residence of Decedent State MD		10b. County Frederick	
10c. City, Town or Location Middletown		10d. Inside City Limits 1 Yes 2 No	
10e. Street and Number 7307 Countryside Dr.		10f. Zip Code 21769	10g. Citizen of What Country? USA
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: 1953-1954	
13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 4		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 4 salesman	
16b. Kind of Business/Industry transportation		17. Father's Name (First, Middle, Last) Harold Francis Lundregan	
18. Mother's Name (First, Middle, Maiden Surname) Madeline Emma Mattis		19a. Informant's Name/Relationship (Type, Print) Virginia A. Lundregan (Wife)	
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7307 Countryside Dr., Middletown, MD 21769		20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) 1 <input type="checkbox"/> Burial	
20b. Place of Disposition (Name of cemetery, crematory or other place) Lutheran cemetery		Date 4/5/07	20c. Location - City or Town, State Middletown, MD
21. Signature of Funeral Service Licensee See et al		22. Name and Address of Facility Donald B. Thompson Funeral Home 31 E. main St., Middletown, MD 21769	
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Immediat Cause (Final disease or condition resulting in death) Myocardial Ischemia		Approximate Interval Between Onset and Death hours	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last CHOLANGIO CARCINOMA		Approximate Interval Between Onset and Death months	
23b. Due to (or as a consequence of): a. Due to (or as a consequence of): CHOLANGIO CARCINOMA			
b. Due to (or as a consequence of): CHOLANGIO CARCINOMA			
c. Due to (or as a consequence of): CHOLANGIO CARCINOMA			
d. Due to (or as a consequence of): CHOLANGIO CARCINOMA			
23c. IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year	
23e. Did tobacco use contribute to the cause of death? Cancer cachexia		23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown	
23f. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)	
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year) M	28b. Time of Injury M
		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	
29a. Certifier 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		28f. Location (Street and Number or Rural Route Number, City or Town, State) 46 B Thomas Johnson Drive Frederick MD 21702	
29b. Signature and title of certifier A.Z. HEGAZI, MD		29c. License number D 44164	29d. Date signed (Month, Day, Year) 4-4-07
31. Date filed (Month, Day, Year) APR 04 2007		32. Registrar's Signature Reverend B. Speer	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2007 12263

1 - For
State
RegistrarPhysician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month APRIL Day 3 Year 2007		3. Time of Death 0519 A.M.
RODNEY LEE LEATHERMAN		4b. City, Town, or Location of Death HAGERSTOWN		4c. County of Death WASHINGTON
4a. Facility Name (If not institution, give street and number) WASHINGTON COUNTY HOSPITAL		4b. City, Town, or Location of Death HAGERSTOWN		4c. County of Death WASHINGTON
5. Social Security Number 215-44-9601		6. Sex 1 M	7. Age (In yrs. last birthday) 62 Yrs.	If Under 1 Year Months Days Hours Min. 8. Date of Birth (Month, Day, Year) MARCH 21, 1945
9. Birthplace (State or Foreign Country) MARYLAND		10. Inside City Limits 1 Yes 2 No		
10a. State MARYLAND		10b. County WASHINGTON		10c. City, Town or Location SHARPSBURG
10e. Street and Number 17429 Taylors Landing Road		10f. Zip Code 21782		10g. Citizen of What Country? U.S.A.
11. Marital Status 1 Never Married 2 Married		12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No Specify:	14. Race - American Indian, Black, White, etc. WHITE
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) OWNER & OPERATOR		16b. Kind of Business/Industry HOMEBUILDING COMPANY
17. Father's Name (First, Middle, Last) ALLEN GARDNER LEATHERMAN SR.		18. Mother's Name (First, Middle, Maiden Surname) HAZEL MARIE GRIFFITH		
19a. Informant's Name/Relationship (Type, Print) ANNA M. LEATHERMAN/SPOUSE		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17429 TAYLORS LANDING ROAD, SHARPSBURG, MD 21782		
20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State		20b. Place of Disposition (Name of cemetery, crematory or other place) MOUNTAIN VIEW CEM.	Date 4/06/2007	20c. Location - City or Town, State SHARPSBURG, MARYLAND
21. Signature of Funeral Service Licensee Paul M. Dean		22. Name and Address of Facility BAST FUNERAL HOME	22. Name and Address of Facility 7606 Old National Pike Boonsboro, Maryland 21713	
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		Approximate Interval Between Onset and Death		
a. Cardio-vascular disease Due to (or as a consequence of):				
b. _____ Due to (or as a consequence of):				
c. _____ Due to (or as a consequence of):				
d. _____				
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown		23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown		23d. Date of delivery Month Day Year
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. End Stage Renal disease (Kidney transplant)		23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown		
25. Was case referred to medical examiner? 1 Yes 2 No		26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)		
27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide		28a. Date of Injury (Month, Day, Year)	28b. Time of Injury M	28c. Injury at Work? 1 Yes 2 No
5 Pending investigation 6 Could not be determined		28d. Describe how injury occurred		28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)
29a. Certifier (Check only one) 1 Certifying Physician 2 Medical Examiner		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29b. Signature and title of certifier Oscar Adler, M.D.		29c. License number D0063101		29d. Date signed (Month, Day, Year) 4/4/07
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Oscar Adler, M.D. 12931 Oak Hill Avenue, Hagerstown, Maryland 21742				
31. Date filed (Month, Day, Year) APR 05 2007		32. Registrar's Signature Barbara S. Sparks		

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transit once.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

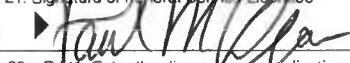
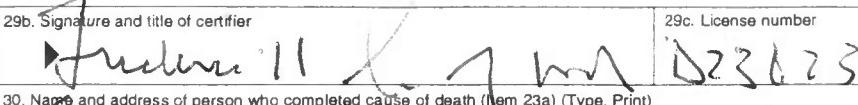
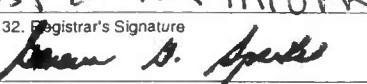
Amend 4b per Dr

Amend 10c, 10f, 19b

State of Maryland / Department of Health and Mental Hygiene
1- State Registrar WCHD/SH 4/10/07 per FH

Certificate of Death

Reg. No. 2007 12264

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last)							2. Date of Death Month Day Year	3. Time of Death	
	WILLIAM ELWOOD LOWERY							MARCH 31 2007	12:05 A M	
Funeral Director	4a. Facility Name (If not institution, give street and number)			4b. City, Town, or Location of Death			4c. County of Death			
	5023 WOODSTOCK LANE			Rohrersville BOONSBORO			WASHINGTON			
	5. Social Security Number		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 75 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) DEC. 19, 1931	9. Birthplace (State or Foreign Country) MARYLAND		
	Usual Residence of Decedent		10a. State MARYLAND			10b. County WASHINGTON			10c. City, Town or Location BOONSBORO Rohrersville	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	10e. Street and Number 5023 WOODSTOCK LANE					10f. Zip Code 21713 21779			10g. Citizen of What Country? U.S.A.	
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: white	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+)			16b. Kind of Business/Industry OWNER & OPERATOR			16c. Kind of Business/Industry MILK TRANSPORT CO.	
	17. Father's Name (First, Middle, Last) JOHN WILLIAM HENRY LOWERY		18. Mother's Name (First, Middle, Maiden Surname) VIOLET LEONA BOWERS							
	19a. Informant's Name/Relationship (Type, Print) SHIRLEY LOWERY/SPOUSE		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5023 WOODSTOCK LANE, ROHRERSVILLE, MD 21713							
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) CEDAR LAWN MEM. PARK			Date 4/03/2007	20c. Location - City or Town, State HAGERSTOWN, MARYLAND			
	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility BAST FUNERAL HOME			7606 Old National Pike Boonsboro, Maryland 21713				
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		23b. Due to (or as a consequence of): <i>Car accident, unknown primary, metastatic</i>			23c. Approximate Interval Between Onset and Death				
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		a. Due to (or as a consequence of): <i>metastatic</i>							
			b. Due to (or as a consequence of):							
			c. Due to (or as a consequence of):							
			d. Due to (or as a consequence of):							
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year				
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown				
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			23f. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown				
	27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)			28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)				
	29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								29d. Date signed (Month, Day, Year)	
	29b. Signature and title of certifier 		29c. License number D23623						April 2, 2007	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Frederick H. Smith III, M.D., Medical Campus Rel Suite 130									
	31. Date filed (Month, Day, Year) APR 02 2007		32. Registrar's Signature 			33. Date signed (Month, Day, Year) Hagerstown, MD 21713				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 12265

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Thomas Edward Lowe II						2. Date of Death Month MARCH Day 27 Year 2007	3. Time of Death 7:15 A.M.	
	4a. Facility Name (If not institution, give street and number) Reeders Memorial Home			4b. City, Town, or Location of Death Boonsboro			4c. County of Death Washington		
Funeral Director	5. Social Security Number 212-36-9683	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 66 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) Oct. 22, 1940	9. Birthplace (State or Foreign Country) Maryland		
To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State Maryland 10b. County Frederick 10c. City, Town or Location Frederick						10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
	10e. Street and Number 610 N. Market Street			10f. Zip Code 21701			10g. Citizen of What Country? United States		
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No 1964- If Yes, Give Year or Dates: 1970		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Circulation Manager		16b. Kind of Business/Industry Newspaper				
	17. Father's Name (First, Middle, Last) William C. Lowe			18. Mother's Name (First, Middle, Maiden Surname) Mary Louise Hamm					
	19a. Informant's Name/Relationship (Type, Print) Kevin Lowe / Brother			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 104 Sherris Way, Smithsburg, MD 21783					
Physician /Medical Examiner	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Resthaven Memorial Gardens		Date March 30, 2007	20c. Location - City or Town, State Frederick, Maryland			
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee ►		22. Name and Address of Facility Resthaven Funeral Services, Skkot Cody P.A. 9501 Catoctin Mtn. Hwy. Frederick, MD 21701						
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of): Cancer of head and neck						Approximate Interval Between Onset and Death 2 months.		
	b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):								
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome pf pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year			
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown		
							24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
							24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
	27. Manner of Death <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred		
	28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State)		
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
	29b. Signature and title of certifier ►						29c. License number D44996		29d. Date signed (Month, Day, Year) March 27, 2007
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. ZAFAR MALIK, 20311 LAPPANS ROAD, BOONSBORO, MARYLAND 21713						301-432-8470		
State Registrar	31. Date filed (Month, Day, Year) APR 03 2007		32. Registrar's Signature John B. [Signature]						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2007 12266
Reg. No.

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) PONZELLA ANNETTE CUTLIP MECK					2. Date of Death Month Day Year April 9, 2007	3. Time of Death 7:26 PM		
	4a. Facility Name (If not institution, give street and number) Harford Memorial Hospital		4b. City, Town, or Location of Death Havre de Grace			4c. County of Death Harford			
Funeral Director	5. Social Security Number 218-38-2705	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 60 Yrs.	If Under 1 Year Months Days Hours Min. If Under 24 Hrs.	8. Date of Birth (Month, Day, Year) 5/12/1946	9. Birthplace (State or Foreign Country) Virginia			
To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State MD. 10b. County Harford 10c. City, Town or Location Havre de Grace					10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
	10e. Street and Number 100 Revolution Street Apt. 411		10f. Zip Code 21078			10g. Citizen of What Country? United States			
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: 12	13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	14. Race - American Indian, Black, White, etc. Specify: White					
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Housewife	16b. Kind of Business/Industry Home						
	17. Father's Name (First, Middle, Last) Ottis Lee Mullins	18. Mother's Name (First, Middle, Maiden Surname) Inis Muriel Mullins							
	19a. Informant's Name/Relationship (Type, Print) Thomas Meck (Husband)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 100 Revolution St. Havre de Grace, Md. 21078							
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) M. Blacken Kurtz	20b. Place of Disposition (Name of cemetery, crematory or other place) Carroll Cremation	Date 4/12/2007	20c. Location - City or Town, State Hampstead, Maryland					
	21. Signature of Funeral Service Licensee M. Blacken Kurtz	22. Name and Address of Facility Jarrettsville, Maryland E.G. Kurtz & Son Funeral Home, P.A.							
Physician /Medical Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) TUMOR LYSIS SYNDROME							Approximate Interval Between Onset and Death	
	23b. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last METASTATIC UTERINE CANCER								
	23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown							23d. Date of delivery Month Day Year	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ISCHEMIC HEART DISEASE							23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
								24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)	
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred			
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 35 FULFORD AVE, BEAVER, MD							28f. Location (Street and Number or Rural Route Number, City or Town, State)	
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							29d. Date signed (Month, Day, Year) APRIL 9, 2007	
	29b. Signature and title of certifier Andrew Nowakowski MD							29c. License number DO 8096	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ANDREW NOWAKOWSKI MD								
	31. Date filed (Month, Day, Year) APR 17 2007		32. Registrar's Signature John B. [Signature]						

Baltimore, Maryland 21215-0036

Permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified once.

Division of Vital Records, P.O. Box 68760, Es

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit

2
State
Registrar

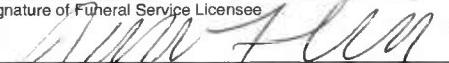
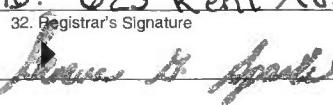
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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 12267

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Victor N. Merkel					2. Date of Death Month Day Year APRIL 9 2007	3. Time of Death 23:09 M
	4a. Facility Name (If not institution, give street and number) MEMORIAL HOSPITAL			4b. City, Town, or Location of Death CUMBERLAND		4c. County of Death ALLEGANY	
Funeral Director	5. Social Security Number 217-10-5446	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 92 Yrs.	If Under 1 Year Months Days Hours Min.	8. Date of Birth (Month, Day, Year) Aug 27, 1914	9. Birthplace (State or Foreign Country) PA	
To Be Completed by Funeral Director	10a. State MD			10b. County Allegany	10c. City, Town or Location Cumberland	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
	10e. Street and Number 511 Fayette Street			10f. Zip Code 21502		10g. Citizen of What Country? USA	
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: WWII		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: white	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) laborer machine shop		16b. Kind of Business/Industry tire company		
	17. Father's Name (First, Middle, Last) George Merkel			18. Mother's Name (First, Middle, Maiden Surname) Hulda Richardson Merkel			
	19a. Informant's Name/Relationship (Type, Print) Victor Merkel son			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 470 Goethe Street Cumberland MD 21502			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) SS Peter and Paul Cemetery			20b. Place of Disposition (Name of cemetery, crematory or other place) SS Peter and Paul Cemetery	Date 4/13/2007	20c. Location - City or Town, State Cumberland MD	
	21. Signature of Funeral Service Licensee 			22. Name and Address of Facility Scarpelli Funeral Home, PA 108 Virginia Avenue: Cumberland, MD 21502			
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Renal failure Approximate Interval Between Onset and Death Unknown Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Congestive heart failure Approximate Interval Between Onset and Death Unknown						
Medical Certification: To Be Completed by Physician/Medical Examiner	23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown			23c. If yes, outcome pf pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown <input type="checkbox"/> Other (specify) _____		23d. Date of delivery Month Day Year	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						
	23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown						
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No			
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide			28a. Date of Injury (Month, Day Year) M	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred
	28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)						
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.			29c. License number D40478		29d. Date signed (Month, Day, Year) 4/10/07	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Afag Ahmad MD 625 Kent Ave. Cumberland, MD. 21502						
State Registrar	31. Date filed (Month, Day, Year) APR 17 2007		32. Registrar's Signature 				

Division or Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

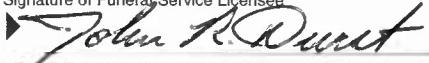
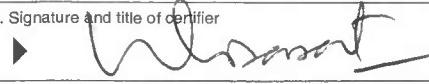
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 12268

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Joseph P. Martirano, Sr.				2. Date of Death Month Day Year APRIL 1ST, 2007	3. Time of Death 16:55 M
	4a. Facility Name (If not institution, give street and number) MEMORIAL HOSPITAL		4b. City, Town, or Location of Death CUMBERLAND		4c. County of Death ALLEGANY	
Funeral Director	5. Social Security Number 216-22-5953	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 81 Yrs.	If Under 1 Year Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 01/05/1926	9. Birthplace (State or Foreign Country) Maryland	
	Usual Residence of Decedent 10a. State Maryland		10b. County Allegany		10c. City, Town or Location Frostburg	
10e. Street and Number 203 Espy Avenue		10f. Zip Code 21532		10g. Citizen of What Country? U.S.A.		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: WWII		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Deputy Superintendent		16b. Kind of Business/Industry Board of Education		
17. Father's Name (First, Middle, Last) Michael Joseph Martirano		18. Mother's Name (First, Middle, Maiden Surname) Mary Susan Zumpano				
19a. Informant's Name/Relationship (Type, Print) Mary F. Martirano wife		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 203 Espy Ave., Frostburg, MD 21532				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Frostburg Memorial Park		Date 03/09/07	20c. Location - City or Town, State Frostburg, Maryland	
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Durst Funeral Home		57 Frost Ave. Frostburg, MD 21532		
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		23b. Approximate Interval Between Onset and Death one week				
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last						
a. Due to (or as a consequence of): cerebrovascular accident						
b. Due to (or as a consequence of):						
c. Due to (or as a consequence of):						
d. Due to (or as a consequence of):						
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. aspiration pneumonia						
23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown						
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year) M		28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
		28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29b. Signature and title of certifier 		29c. License number D-0063118		29d. Date signed (Month, Day, Year) 04-01-2007		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Wirasat Hasnain, M.D., 900 Seton Dr., Cumberland, MD 21502						
31. Date filed (Month, Day, Year) APR 03 2007		32. Registrar's Signature 				

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

9/1/VA
WHS

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene
Certificate of Death

Reg. No. 2007 12269

1 - For State Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last)				2. Date of Death				3. Time of Death					
	RITA MALLOY				Month Day Year				MARCH 19 2007					
Funeral Director	4a. Facility Name (If not institution, give street and number)				4b. City, Town, or Location of Death				4c. County of Death					
	MEMORIAL HOSPITAL				CUMBERLAND				ALLEGANY					
	5. Social Security Number		6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth (Month, Day, Year)		9. Birthplace (State or Foreign Country)					
	220-30-8116		1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	76 Yrs.	Months Days	Hours Min.	February 16, 1931		Maryland					
To Be Completed by Funeral Director	Usual Residence of Decedent				10c. City, Town or Location				10d. Inside City Limits					
	Maryland	Allegany		Cumberland				1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No						
	10e. Street and Number				10f. Zip Code		10g. Citizen of What Country?							
	701 Furnace Street				21502-		U.S.A.							
	11. Marital Status		12. Was Decedent Ever in U.S. Armed Forces?		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)				14. Race - American Indian, Black, White, etc.					
	1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married		1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				Specify: White					
	3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced													
	15. Decedent's Education (Specify only highest grade completed)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)				16b. Kind of Business/Industry					
	Elementary/Secondary (0-12)		College (1-4 or 5+)		homemaker				homemaker					
	6		0											
	17. Father's Name (First, Middle, Last)				18. Mother's Name (First, Middle, Maiden Surname)									
	Joseph Malloy				Margaret Murray									
	19a. Informant's Name/Relationship (Type. Print)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)									
	James Malloy brother				15704 Mile Lane N.W.				Mount Savage Maryland 21545					
	20a. Method of Disposition				20b. Place of Disposition (Name of cemetery, crematory or other place)				Date	20c. Location - City or Town, State				
	1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State				Saint Patrick's Parish Cemetery				March 22, 2007	Mt. Savage Maryland				
	4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)													
	21. Signature of Funeral Service Licensee				22. Name and Address of Facility									
					Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532									
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.								Approximate Interval Between Onset and Death					
	Immediate Cause (Final disease or condition resulting in death)													
	23b. Was decedent pregnant in the past 12 months?				23c. If yes, outcome of pregnancy				23d. Date of delivery					
	1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown				1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) _____ 9 <input type="checkbox"/> Unknown				Month	Day	Year			
	23e. Did tobacco use contribute to the cause of death?													
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				COPD, Pneumonia, Thrombocytopenia				1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown					
	23f. Was case referred to medical examiner?				26. Place of Death (Check only one)									
	1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)									
	27. Manner of Death				28a. Date of Injury (Month, Day Year)				28b. Time of Injury		28c. Injury at Work?		28d. Describe how injury occurred	
	1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				M				1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No					
	28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)								28f. Location (Street and Number or Rural Route Number, City or Town, State)					
	29a. Certifier (Check only one)				1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
	29b. Signature and title of certifier				29c. License number				29d. Date signed (Month, Day, Year)					
					D0064167				3/20/07					
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)													
	QAISRANI, NOSHIN 47 VIRGINIA AVENUE CUMBERLAND, MD 21502													
	31. Date filed (Month, Day, Year)				32. Registrar's Signature									
	MAR 21 2007													

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit slip.

Division or Vital Records, P.O. Box 68760,

Within 24 hours after death.

To the Hospital or Attending Physician: After this certificate has been signed by the attending physician, page 2 should be detached for use as the burial-transit slip.

2

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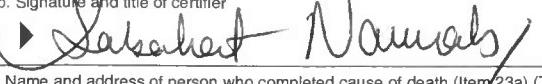
State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene
Certificate of Death

Reg. No. 2007 12270

1- For State Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) DARLEEN CLARA MICHAEL					2. Date of Death Month Day Year 04 04 2007	3. Time of Death 1836 M			
	4a. Facility Name (If not institution, give street and number) MEMORIAL HOSPITAL			4b. City, Town, or Location of Death CUMBERLAND		4c. County of Death ALLEGANY				
Funeral Director	5. Social Security Number 214-62-4094	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 57 yrs.	If Under 1 Year Months Days Hours Min. 	8. Date of Birth (Month, Day, Year) May 14, 1949	9. Birthplace (State or Foreign Country) Maryland				
	Usual Residence of Decedent 10a. State MD			10b. County Garrett			10c. City, Town or Location Frostburg	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
To Be Completed by Funeral Director	10e. Street and Number 16430 National Pike			10f. Zip Code 21532		10g. Citizen of What Country? USA				
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Custodian		16b. Kind of Business/Industry MD DNR					
	17. Father's Name (First, Middle, Last) Thomas Wilhelm			18. Mother's Name (First, Middle, Maiden Surname) Hilda Minnick						
	19a. Informant's Name/Relationship (Type, Print) Harry A. Michael/Husband			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 16430 National Pike, Frostburg, MD 21532						
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Country Side Crem.		Date April 9, 2007	20c. Location - City or Town, State Davidsville, PA				
Physician /Medical Examiner	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Newman Funeral Homes, P.A. P.O. Box 275, Grantsville, MD 21536							
	23a. Part I. Enter the disease, complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							Approximate Interval Between Onset and Death 1 MO.		
	<p>a. DIABETES MELLITUS Due to (or as a consequence of):</p> <p>b. PANCREATIC CANCER Due to (or as a consequence of):</p> <p>c. CARDIOGENIC SHOCK Due to (or as a consequence of):</p> <p>d. ACUTE MYOCARDIAL INFARCTION</p>									
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome pf pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify)				23d. Date of delivery Month Day Year			
Medical Certification: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. RENAL FAILURE, ANTERIOR WALL ANEURYSM OF HEART							23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown		
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DCA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year) 	28b. Time of Injury M	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred				
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 			28f. Location (Street and Number or Rural Route Number, City or Town, State) 				
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29d. Date signed (Month, Day, Year) 4/5/7							
	29b. Signature and title of certifier 		29c. License number D58655							
4	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NAWAB, SABAHT, M.D., 32 CORPORATE DRIVE, P.O. BOX 265, GRANTSVILLE, MD 21536									
State Registrar	31. Date filed (Month, Day, Year) APR - 9 2007		32. Registrar's Signature 							

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend 10c-10d
For State WCHD / SH 4/5/07
Registrar per FH

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 1227

1-

State WCHD / SH 4/5/07
Registrar per FH

Physician / Medical Examiner

Funeral Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician / Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

1. Decedent's Name (First, Middle, Last)		MCNEAL		2. Date of Death Month April Day 2 Year 2007	3. Time of Death AM
COLLEEN					
4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of Death		4c. County of Death	
THE JOHNS HOPKINS HOSPITAL		BALTIMORE CITY			
5. Social Security Number	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 25 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Hours	8. Date of Birth (Month, Day, Year) May 8, 1981
205-70-4500					9. Birthplace (State or Foreign Country) Pennsylvania
Usual Residence of Decedent		10a. State Pennsylvania 10b. County Cumberland 10c. City, Town or Location Enola East Pennsboro Township, Enola			
		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
10e. Street and Number 1050 Hemlock Lane		10f. Zip Code 17025		10g. Citizen of What Country? USA	
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
				14. Race - American Indian, Black, White, etc. Specify: White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Customer Service Representative		16b. Kind of Business/Industry Health Care	
17. Father's Name (First, Middle, Last) Michael F. McNeal		18. Mother's Name (First, Middle, Maiden Surname) Janet L. Parry			
19a. Informant's Name/Relationship (Type, Print) Michael F. McNeal (Father)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1050 Hemlock Lane, Enola, PA 17025			
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Hollinger Crematory		Date 4/7/2007	20c. Location - City or Town, State Mt. Holly Springs, PA
21. Signature of Funeral Service Person See T Paul J. Lochstampfor		22. Name and Address of Facility Lochstampfor Funeral Home, Inc. 48 S. Church Street, Waynesboro, PA 17268			
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		Approximate Interval Between Onset and Death 3 YEARS			
a. PULMONARY HYPER TENSION Due to (or as a consequence of):					
b. PULMONARY EMBOLISM Due to (or as a consequence of):		3 YEARS			
c. _____ Due to (or as a consequence of):					
d. _____					
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____ <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		23f. Did alcohol contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred
		28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier OLCAY AKSOY, MEDICAL DOCTOR		29c. License number RES-000		29d. Date signed (Month, Day, Year) APRIL 2, 2007	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) OLCAY AKSOY, THE JOHNS HOPKINS HOSPITAL, 600 NORTH WOLFE STREET 21287 BALTIMORE, MARYLAND					
31. Date filed (Month, Day, Year) APR 05 2007		32. Registrar's Signature <i>Leanne D. Spangler</i>			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 12272

1- For State
Registrar

Physician/ Medical Examiner	1. Decedent's Name (First, Middle, Last) JAMES PAUL MERCER JR.				2. Date of Death Month April 10, 2007 Day Year	3. Time of Death 1045 hrs	
	4a. Facility Name (if not institution, give street and number) 708 Cross Street		4b. City, Town, or Location of Death Brooklyn		4c. County of Death Anne Arundel		
Funeral Director	5. Social Security Number 217-58-0136	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 54 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min	8. Date of Birth (MM/DD/YYYY) 8-13-52	9. Birthplace (State or Foreign Country) N.C.
	10a. State MD		10b. County ANNE ARUNDEL		10c. City, Town or Location BROOKLYN PARK		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
To Be Completed by Funeral Director	10e. Street and Number 708 CROSS ST.		10f. Zip Code 21225		10g. Citizen of What Country U.S.A.		
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No specify: specify: WHITE		14. Race - American Indian, Black, White, etc.
Physician /Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 3		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) CHIEF EXEC. OFFICER		16b. Kind of Business/Industry PLASTICS MFG.		
	17. Father's Name (First, Middle, Last) JAMES PAUL MERCER SR.		18. Mother's Name (First, Middle, Maiden Surname) BETTY JEAN PARRISH				
Medical Certification: To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) DEBORAH ANN MERCER, WIFE		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 708 CROSS ST. BROOKLYN PARK, MD. 21225				
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other Specify: <i>ANATOMY GIFTS REGISTRY 4-14-07</i>		20b. Place of Disposition (Name of cemetery, crematory or other place) HANOVER, MD.		Date	20c. Location - City or Town, State	
21. Signature of Funeral Service Licensee <i>S. J. Deacon</i>		22. Name and Address of Facility Daugherty Family Funeral Home And Cremation Center, P.A. 2601 Mountain Road - Pasadena, MD. 21122					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.						Approximate Interval Between Onset and Death	
Immediate Cause (Final disease or condition resulting in death)		a. Cocaine and narcotic intoxication Due to (or as a consequence of):					
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		b. _____ Due to (or as a consequence of):					
c. _____ Due to (or as a consequence of):		d. _____					
<input checked="" type="checkbox"/> UNPENDED <input type="checkbox"/> AMENDED		#23a, 27, 28a-f, per ME, g866, 4/21/07 TT					
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown	
						24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other: Scene					
27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input checked="" type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Homicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year) Fnd 4/10/2007	28b. Time of Injury Fnd 10:35 am	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	28d. Describe how injury occurred unknown		
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) found at residence		28f. Location (Street and Number or Rural Route Number, City or Town, State) 708 Cross Street Brooklyn, MD			
29a. Certifier 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
29b. Signature and title of certifier <i>Ling Li, MD</i>		29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) April 11, 2007			
30. Name and address of person who completed cause of death (Item 23a) Ling Li, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201							
31. Date filed (Month, Day, Year) APR 17 2007		32. Registrar's Signature <i>[Signature]</i>					

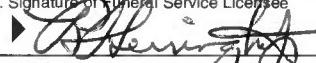
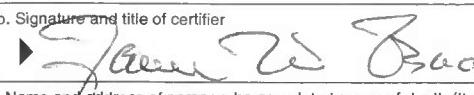
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 12273

1- For State Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Virginia L. Mitchell							2. Date of Death Month 4 Day 1 Year 07	3. Time of Death 0410 A M	
	4a. Facility Name (If not institution, give street and number) Coastal Hospice At The Lake			4b. City, Town, or Location of Death Salisbury			4c. County of Death Wicomico			
Funeral Director	5. Social Security Number 222-14-4929	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 83 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Hours	Min.	8. Date of Birth (Month, Day, Year) NOV 2, 1923	9. Birthplace (State or Foreign Country) DELAWARE		
Usual Residence of Decedent 10a. State DELAWARE 10b. County SUSSEX 10c. City, Town or Location DAGSBORO 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										
10e. Street and Number 30209 VINES CREEK ROAD				10f. Zip Code 19939			10g. Citizen of What Country? U.S.A.			
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: WHITE		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) SCHOOL PRINCIPAL			16b. Kind of Business/Industry EDUCATION					
17. Father's Name (First, Middle, Last) WILLIAM LAYTON					18. Mother's Name (First, Middle, Maiden Surname) MARIE ELLENSWORTH					
19a. Informant's Name/Relationship (Type, Print) APRIL M. POWELL / DAUGHTER				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 30209 VINES CREEK ROAD, DAGSBORO, DELAWARE 19939						
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) CAREY'S CEMETERY		20b. Place of Disposition (Name of cemetery, crematory or other place) CAREY'S CEMETERY			Date APR 5, 2007	20c. Location - City or Town, State MILLSBORO, DELAWARE				
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility WATSON FUNERAL HOME 211 WASHINGTON ST., MILLSBORO, DELAWARE 19966								
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		23b. Part II. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last			23c. Approximate Interval Between Onset and Death					
<p>a. Due to (or as a consequence of): ACHEIMER'S DISEASE</p> <p>b. Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. Due to (or as a consequence of):</p>										
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. EMPHYSEMA										
23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown										
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death Check only one Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year) M		28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		28e. Place of injury At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)						
29b. Signature and title of certifier 		29c. License number D14256			29d. Date signed (Month, Day, Year) 4/1/07					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) COASTAL HOSPICE AT THE LAKE DEERSHEAD SALISBURY MD 21801										
31. Date filed (Month, Day, Year) APR 03 2007		32. Registrar's Signature 								

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
 Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 12274

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) LILLIAN G. O'BRIEN							2. Date of Death Month Day Year MARCH 13, 2007	3. Time of Death 9:00 P.M.
	4a. Facility Name (If not institution, give street and number) DEVLIN MANOR NURSING HOME				4b. City, Town, or Location of Death CUMBERLAND			4c. County of Death ALLEGANY	
Funeral Director	5. Social Security Number 234-68-4716	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 79 Yrs.	If Under 1 Year Months 0	If Under 24 Hrs. Days 0	Hours 0	Min. 0	8. Date of Birth (Month, Day, Year) JAN. 12, 1928	9. Birthplace (State or Foreign Country) WEST VIRGINIA
	Usual Residence of Decedent 10a. State WV 10b. County MINERAL 10c. City, Town or Location RIDGELEY								
To Be Completed by Funeral Director	10e. Street and Number ROUTE 3, BOX 394-B				10f. Zip Code 26753			10g. Citizen of What Country? U.S.A.	
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: WHITE	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) CLERK			16b. Kind of Business/Industry RETAIL STORE	
	17. Father's Name (First, Middle, Last) CHARLES F. WEAVER				18. Mother's Name (First, Middle, Maiden Surname) DAISY PAIGE BALDWIN				
	19a. Informant's Name/Relationship (Type, Print) PAULINE CHANEY / DAUGHTER				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ROUTE 3, BOX 394-B, RIDGELEY, WV 26753				
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) ABE CEMETERY			Date 03/16/2007	20c. Location - City or Town, State RIDGELEY, WV		
Physician /Medical Examiner	21. Signature of Funeral Service Licensee <i>Henry A. Upchurch</i>				22. Name and Address of Facility UPCHURCH FUNERAL HOME, P.A. 202 GREENE STREET, CUMBERLAND, MD 21502				
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)				<i>Acute Renal Failure</i>			Approximate Interval Between Onset and Death 3 weeks	
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				<i>Hypertension</i>			<i>4 weeks</i>	
					<i>Failure to Thrive</i>			<i>2 months</i>	
Physician /Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify)			23d. Date of delivery Month Day Year			
Medical Certification: To Be Completed by Physician/Medical Examiner	<i>Birth asphyxia, venous DVT</i>							23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
								24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred		
	5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined								
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
	29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
	29b. Signature and title of certifier <i>John R. Bellino Jr.</i>		29c. License number 00017565-			29d. Date signed (Month, Day, Year) Mar. 14, 2007			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) A.J. Bellino Jr. 922 Net'l Hwy Luray VA 21502								
State Registrar	31. Date filed (Month, Day, Year) Mar 23 2007		32. Registrar's Signature <i>John R. Bellino Jr.</i>						

Baltimore, Maryland 21215-0036

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transit

Medical Certification: To Be Completed by Physician/Medical Examiner

6

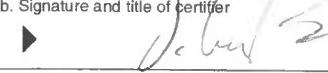
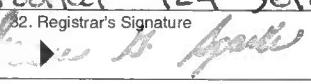
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 12275

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) CHARLES WILLIAM OROURKE					2. Date of Death Month MARCH Day 26, Year 2007	3. Time of Death 1810 M	
	4a. Facility Name (If not institution, give street and number) WMHS-Memorial Campus			4b. City, Town, or Location of Death CUMBERLAND		4c. County of Death ALLEGANY		
Funeral Director	5. Social Security Number 217-42-6351	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 62 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Hours	8. Date of Birth (Month, Day, Year) 02/18/1945	9. Birthplace (State or Foreign Country) Maryland	
	Usual Residence of Decedent 10a. State MD 10b. County Allegany			10c. City, Town or Location Cumberland			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
To Be Completed by Funeral Director	10e. Street and Number 107 Bellevue Street			10f. Zip Code 21502		10g. Citizen of What Country? USA		
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No 1963- If Yes, Give Year or Dates: 1967		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Truck Driver		16b. Kind of Business/Industry Fuel			
	17. Father's Name (First, Middle, Last) George Patrick O'Rourke			18. Mother's Name (First, Middle, Maiden Surname) Elizabeth Cecelia O'Neal				
	19a. Informant's Name/Relationship (Type, Print) Betty Wilson /sister			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3860 Braveheart Drive, Frederick, MD 21704				
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) MD Vet. Cem. @ Rocky Gap		Date 03/30/2007	20c. Location - City or Town, State Flintstone, MD		
	21. Signature of Funeral Service Licensee 			22. Name and Address of Facility Adams Family Funeral Home, P.A. 404 Decatur Street, Cumberland, MD 21502				
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							
	<p>a. Stage IV Lung Cancer Due to (or as a consequence of):</p> <p>b. _____ Due to (or as a consequence of):</p> <p>c. _____ Due to (or as a consequence of):</p> <p>d. _____</p> <p>Approximate Interval Between Onset and Death 1 year</p>							
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown <input type="checkbox"/> Other (specify) _____			23d. Date of delivery Month Day Year		
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
	23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown							
	<p>24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>							
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
	<p>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)</p> <p>26. Place of Death (Check only one)</p>							
	<p>27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide</p> <p>28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>28d. Describe how injury occurred</p>							
	28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)							
	28f. Location (Street and Number or Rural Route Number, City or Town, State)							
	<p>29a. Certifier <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.</p> <p>29b. Signature and title of certifier </p> <p>29c. License number D36766</p> <p>29d. Date signed (Month, Day, Year) MARCH 27, 2007</p>							
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Vikramaditya Poorni 924 Seton Drive Cumberland, MD. 21502							
	31. Date filed (Month, Day, Year) MAR 28 2007		32. Registrar's Signature 					

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 2a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

11/VA

MRS

State
Registrar

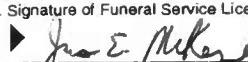
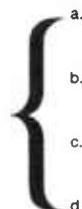
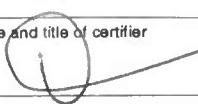
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 12276

1 - For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Anna Lee Oester					2. Date of Death Month April Day 01, 2007 Year		3. Time of Death 10:45 A. M.					
	4a. Facility Name (If not institution, give street and number) 1536D Oldtown Manor			4b. City, Town, or Location of Death Cumberland		4c. County of Death Allegany							
Funeral Director	5. Social Security Number 215-34-4201	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 69 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) April 07, 1937	9. Birthplace (State or Foreign Country) Maryland						
	Usual Residence of Decedent 10a. State Maryland			10b. County Allegany		10c. City, Town or Location Cumberland			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
To Be Completed by Funeral Director	10e. Street and Number 1536D Oldtown Manor			10f. Zip Code 21502		10g. Citizen of What Country? U.S.A.							
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White						
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) T2			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (4-40r 5+) 2 Medical Technician			16b. Kind of Business/Industry Drugs						
	17. Father's Name (First, Middle, Last) Robert Lee Lantz				18. Mother's Name (First, Middle, Maiden Surname) Anna Cecilia Maffley								
	19a. Informant's Name/Relationship (Type, Print) Paul E. Lantz-Brother			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 514 Salisbury Street, Meyersdale, Pa. 15553									
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Cumberland Crematory		Date April 04, 2007	20c. Location - City or Town, State Cumberland, Maryland						
	21. Signature of Funeral Service Licensee 			22. Name and Address of Facility Eichorn-McKenzie Funeral Home P.A. 8 East Main Street, Lonaconing, Maryland 21539									
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  a. METASTATIC ADENOCARCINOMA LUNG Due to (or as a consequence of): b. _____ Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____								Approximate Interval Between Onset and Death Feb. 2007				
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Unknown				23d. Date of delivery Month Day Year						
Medical Certification: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23e. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown				
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								29b. Signature and title of certifier 			29c. License number D23371	29d. Date signed (Month, Day, Year) APRIL 2, 2007
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Qamar U. Zaman, MD 625 Kent Avenue, Cumberland, Maryland 21502								31. Date filed (Month, Day, Year) APR - 5 2007			32. Registrar's Signature 	

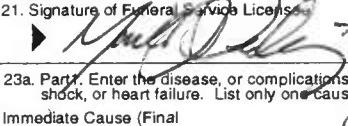
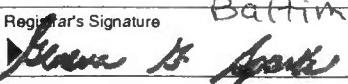
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2007 12277
Reg. No.

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Betty Lee Pickavance						2. Date of Death Month Day Year March 29 2007	3. Time of Death 11:23pm	
	4a. Facility Name (If not institution, give street and number) 4112 Winfield Way			4b. City, Town, or Location of Death Westminster			4c. County of Death Carroll		
Funeral Director	5. Social Security Number 212-32-6802	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 71 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) Sept 1 1935	9. Birthplace (State or Foreign Country) MD		
	Usual Residence of Decedent 10a. State MD 10b. County Carroll 10c. City, Town or Location Westminster						10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
To Be Completed by Funeral Director	10e. Street and Number 4112 Winfield Way			10f. Zip Code 21157			10g. Citizen of What Country? USA		
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker			16b. Kind of Business/Industry Own Home		
17. Father's Name (First, Middle, Last) Levi J. Caudle					18. Mother's Name (First, Middle, Maiden Surname) Carrie Key				
19a. Informant's Name/Relationship (Type, Print) George Pickavance/husband				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4112 Winfield Way Westminster, MD 21157					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Meadowridge Mem Pk			Date 4/02/2007	20c. Location - City or Town, State Elkridge, MD	
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Pritts Funeral Home and Chapel, P.A. 412 Washington Road Westminster, MD 21157					
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Ovarian Cancer Approximate Interval Between Onset and Death								
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Respiratory failure								
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Unknown						23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
								24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)	
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide				28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)								28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29c. License number D 31087				29d. Date signed (Month, Day, Year) 3/30/07	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Peter K. Zuckerman, MD 2411 W. Belvedere Ave. suite 206 Baltimore, MD 21215									
31. Date filed (Month, Day, Year) APR 02 2007				32. Registrar's Signature 					

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transit slip.

Medical Certification: To Be Completed by Physician/Medical Examiner

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department: If Item 27 is marked other than "natural", or items 28a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 12278

1- For
State
Registrar

Physician
/Medical
Examiner

Funeral
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a show any injury or other traumatic event, the Medical Examiner must be notified at once.

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month 3 Day 31 Year 07		3. Time of Death 8:25AM
Teddy I. Riegel				
4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of Death		4c. County of Death
The Dove House		Westminster		Carroll
5. Social Security Number 182-40-9389		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 57 Yrs.	8. Date of Birth Month 1 Year 1950
			If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
9. Birthplace (State or Foreign Country) VA				
10a. State PA		10b. County Adams		10c. City, Town or Location Littlestown
				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
10e. Street and Number 104 Boyer St.		10f. Zip Code 17340		10g. Citizen of What Country? USA
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: Year		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: Specify: white
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+)		16b. Kind of Business/Industry Dispatcher / Wt. master Stone quarry
17. Father's Name (First, Middle, Last) John Riegel		18. Mother's Name (First, Middle, Maiden Surname) Sara Elizabeth Reedy		
19a. Informant's Name/Relationship (Type, Print) Linda Riegel / wife		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 104 Boyer St. Littlestown, PA 17340		
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Carroll Crematory		Date 4/4/07
21. Signature of Funeral Service Licensee ► Richard J. Guile Jr.		22. Name and Address of Facility Little's F.H. 34 Maple Ave. Littlestown, PA		20c. Location - City or Town, State 17340
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Resulting in death) Last				
<p style="text-align: center;">Braun Cancer</p> <p>a. Due to (or as a consequence of):</p> <p>b. Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. _____</p>				
Approximate Interval Between Onset and Death				
23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				
23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown				
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) Twp Hospital		
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
		28d. Describe how injury occurred		
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)
29a. Certifier 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				
29b. Signature and title of certifier ► S. Shah		29c. License number D 36147		29d. Date signed (Month, Day, Year) April 02 2007
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Gettysburg Cancer Center Dr. Satish Shah 20 Expedition Trail, Suite 101, Gettysburg PA 17325				
31. Date filed (Month, Day, Year) APR 03 2007		32. Registrar's Signature Anne B. Foster		

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit slip.

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2007 12279

Reg. No.

1 - For State Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) BARBARA ANN ROBINSON							2. Date of Death Month MARCH Day 27 Year 2007	3. Time of Death 16:00 PM
	4a. Facility Name (If not institution, give street and number) Washington County Hospital			4b. City, Town, or Location of Death Hagerstown			4c. County of Death WASHINGTON		
Funeral Director	5. Social Security Number 215-66-7226	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 50 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) June 29, 1956	9. Birthplace (State or Foreign Country) Maryland		
	Usual Residence of Decedent 10a. State MD 10b. County Washington			10c. City, Town or Location Hagerstown			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
To Be Completed by Funeral Director	10e. Street and Number 11 W. Baltimore St., #126			10f. Zip Code 21740			10g. Citizen of What Country? U.S.A.		
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: 11th			13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: Black			14. Race - American Indian, Black, White, etc. Specify: Black	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11th			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Domestic			16b. Kind of Business/Industry Home		
	17. Father's Name (First, Middle, Last) Samuel Kelly			18. Mother's Name (First, Middle, Maiden Surname) Mary Hodge					
	19a. Informant's Name/Relationship (Type, Print) Ann Bright (Daughter)			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 39 Avalon Ave., Hagerstown, MD 21740					
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) Riverdale Park Cre			20b. Place of Disposition (Name of cemetery, crematory or other place) Riverdale Park Cre			Date 4/3/07	20c. Location - City or Town, State Riverdale, MD	
Physician /Medical Examiner	21. Signature of Funeral Service Employee George R. Snowden			22. Name and Address of Facility SNOWDEN FUNERAL HOME, P.A. 246 N. Washington St, Rockville, MD 20850					
To Be Completed by Physician/Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) CIRRHOSIS OF LIVER								Approximate Interval Between Onset and Death UNKNOWN
	23a. Part II. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last { a. Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):								
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Unknown			23c. If yes, outcome pf pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) 9□Unknown			23d. Date of delivery Month Day Year		
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. HEPATO - RENAL SYNDROME								23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			23f. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide			28a. Date of Injury (Month, Day Year) March	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred		
				28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) At home			28f. Location (Street and Number or Rural Route Number, City or Town, State) Hagerstown, MD 21740		
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
	29b. Signature and title of certifier KODIAH PEPRATH MD			29c. License number 0058181			29d. Date signed (Month, Day, Year) MARCH 28 2007		
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KODIAH PEPRATH 382 S. CLEVELAND AVE, HAGERSTOWN, MD 21740								
State Registrar	31. Date filed (Month, Day, Year) APR 03 2007			32. Registrar's Signature Debra J. Miller					

Baltimore, Maryland 21215-0036

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural"; or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2007 12280

1- For State
Registrar

Reg. No.

Physician/ Medical Examiner	1. Decedent's Name (First, Middle, Last) Robert Charles Record, Sr.				2. Date of Death Month Day Year April 5, 2007	3. Time of Death 1924 hrs			
	4a. Facility Name (if not institution, give street and number) Washington County Hospital		4b. City, Town, or Location of Death Hagerstown		4c. County of Death Washington				
Funeral Director	5. Social Security Number 069-14-0263		6. Sex 1 M 2 F	7. Age (In yrs. last birthday) 85 Yrs.	If Under 1 Year Months Days Hours Min	8. Date of Birth (MM/DD/YYYY) April 15, 1921	9. Birthplace (State or Foreign Country) New York		
	10a. State Maryland		10b. County Washington		10c. City, Town or Location Hagerstown		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
To Be Completed by Funeral Director	10e. Street and Number 16814 Longfellow Court			10f. Zip Code 21740		10g. Citizen of What Country? USA			
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 2			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Electrician			16b. Kind of Business/Industry STATE OF NEW YORK			
17. Father's Name (First, Middle, Last) Wolford Record				18. Mother's Name (First, Middle, Maiden Surname) Edith (Unknown)					
19a. Informant's Name/Relationship (Type, Print) Jacqueline H. Hetterly/Daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5803-C Oleander Place, Frederick, MD 21703					
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other Specify: <i>Roger W. Miller</i>		20b. Place of Disposition (Name of cemetery, crematory or other place) Stauffer Crematory		Date Apr 16, 2007	20c. Location - City or Town, State Frederick, MD				
21. Signature of Funeral Service Licensee <i>Roger W. Miller</i>			22. Name and Address of Facility Stauffer Funeral Home, PA 1621 Opossumtown Pike, Frederick, MD 21702						
Physician Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <u>Complications of dehydration and decubitus ulcer with hypertension due to (or as a consequence of) atherosclerotic cardiovascular disease</u>							Approximate Interval Between Onset and Death	
	b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):								
<input type="checkbox"/> UNPENDED <input type="checkbox"/> AMENDED		#28a,27,28a-f, per ME, g867, 5/22/07 TT							
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown				23d. Date of delivery Month Day Year			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown	
								24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
								24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> OOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other:							
27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input checked="" type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year) Fnd 3/6/2007		28b. Time of Injury Fnd 11:21 am		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28d. Describe how injury occurred subject was restrained and neglected	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) residence						28f. Location (Street and Number or Rural Route Number, City or Town, State) 16814 Longfellow Ct. Hagerstown, MD	
29a. Certifier 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <i>Ling Li, MD</i>							
		29c. License number O.C.M.E.						29d. Date signed (Month, Day, Year) April 6, 2007	
30. Name and address of person who completed cause of death (Item 23a) Ling Li, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201									
State Registrar	31. Date filed (Month, Day, Year) APR 12 2007		32. Registrar's Signature <i>Ling Li, MD</i>						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2007 12281

Reg. No.

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last)						2. Date of Death Month Day Year	3. Time of Death
	Alice Laverne Riley						April 4, 2007	12:47 PM
Funeral Director	4a. Facility Name (If not institution, give street and number)			4b. City, Town, or Location of Death			4c. County of Death	
	Garrett Co. Memorial Hospital			Oakland			Garrett	
5. Social Security Number		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 73 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) Sept. 29, 1933	9. Birthplace (State or Foreign Country) Pennsylvania	
Usual Residence of Decedent								
10a. State MD	10b. County Garrett	10c. City, Town or Location McHenry						10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
10e. Street and Number 198 Skyview Drive, P.O. Box 44			10f. Zip Code 21541			10g. Citizen of What Country? USA		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Waitress		16b. Kind of Business/Industry Restaurant				
17. Father's Name (First, Middle, Last) Stewart Ackerman				18. Mother's Name (First, Middle, Maiden Surname) Anna Jordon				
19a. Informant's Name/Relationship (Type, Print) Connie Guillot/Daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 164, McHenry, MD 21541				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Fritz Church Cem. April 7, 2007 Meyersdale, PA		Date	20c. Location - City or Town, State	
21. Signature of Funeral Service Licensee ► D. Lynn Newman				22. Name and Address of Facility Newman Funeral Homes, P.A. P.O. Box 275, Grantsville, MD 21536				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								
<p>a. Due to (or as a consequence of) Acute Myocardial Infarction</p> <p>b. Due to (or as a consequence of) Atherosclerotic Cardiovascular Disease</p> <p>c. Due to (or as a consequence of):</p> <p>d. Due to (or as a consequence of):</p>								
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown				23d. Date of delivery Month Day Year		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								
23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown								
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No								
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred		
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier ► Robert A. Goralski, M.D., 311 N. 4th St., Oakland, MD 21550								
29c. License number D23979		29d. Date signed (Month, Day, Year) Apr 4, 2007						
31. Date filed (Month, Day, Year) APR - 9 2007		32. Registrar's Signature Suzanne B. Goralski						

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-trust.

Medical Certification: To Be Completed by Physician/Medical Examiner

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 12282

1- For
State
Registrar

Physician
/Medical
Examiner

Funeral
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

Maxine Elaine Ringer
Baltimore, Maryland 21215-0036
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician /Medical Examiner	For State Registrar
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1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death			
Maxine Elaine Ringer	APRIL 04 2007	4:30 A M			
4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death			
Western Maryland Hospital Center	Hagerstown	Washington			
5. Social Security Number	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 82 Yrs.	If Under 1 Year Months Days Hours Min.	8. Date of Birth (Month, Day, Year) Dec. 26 1924	9. Birthplace (State or Foreign Country) Maryland
Usual Residence of Decedent			10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		
10a. State Maryland	10b. County Washington	10c. City, Town or Location Hagerstown			
10e. Street and Number 1315 Woodland Way		10f. Zip Code 21742	10g. Citizen of What Country? U.S.A.		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:	14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Secretary	16b. Kind of Business/Industry Airplane Manufacturing		
17. Father's Name (First, Middle, Last) Charles Haller Saum			18. Mother's Name (First, Middle, Maiden Surname) Mary Susan Johnston		
19a. Informant's Name/Relationship (Type, Print) Gerald Saum / Nephew			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 610 Potomac Ave. Hagerstown Maryland 21742		
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) ► E. K. Ringer		20b. Place of Disposition (Name of cemetery, crematory or other place) Rest Haven Cemetery	Date 4/6/2007	20c. Location - City or Town, State Hagerstown Maryland	
21. Signature of Funeral Service Licensee ► E. K. Ringer			22. Name and Address of Facility Rest Haven Funeral Chapel 1601 Pennsylvania Ave Hagerstown Maryland 21742		
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)			Approximate Interval Between Onset and Death 1 YEAR		
<p>a. Due to (or as a consequence of): METASTATIC BREAST CANCER</p> <p>b. Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. Due to (or as a consequence of):</p>					
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					
23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown					
23f. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
			28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
					28f. Location (Street and Number or Rural Route Number, City or Town, State)
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.			29d. Date signed (Month, Day, Year) APRIL, 04, 2007		
29b. Signature and title of certifier ► M. Daley MD			29c. License number D 0062-895		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Pauline M. Daley, M.D.					
31. Date filed (Month, Day, Year) APR 06 2007					
32. Registrar's Signature Jean B. Speckle					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 12283

1- For State Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>John Arthur Richards</i>					2. Date of Death Month MAR Day 27 Year 2007			3. Time of Death 8:45 PM
	4a. Facility Name (If not institution, give street and number) <i>6640 Granville Court</i>			4b. City, Town, or Location of Death <i>Frederick</i>			4c. County of Death <i>Frederick</i>		
Funeral Director	5. Social Security Number <i>224-46-1763</i>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <i>69 Yrs.</i>	If Under 1 Year Months	If Under 24 Hrs. Hours	8. Date of Birth (Month, Day, Year) <i>Oct. 11, 1937</i>	9. Birthplace (State or Foreign Country) <i>VA.</i>		
To Be Completed by Funeral Director	10a. State <i>Md.</i>			10b. County <i>Frederick</i>	10c. City, Town or Location <i>Frederick</i>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
	10e. Street and Number <i>6640 Granville Court</i>			10f. Zip Code <i>21703</i>			10g. Citizen of What Country? <i>USA</i>		
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <i>N/A</i>			13. Was Decedent of Hispanic Origin? (Specify Yes or No) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: <i>BLACK</i>			14. Race - American Indian, Black, White, etc. Specify: <i>BLACK</i>	
	15. Decedent's Education (Specify only highest grade completed) <i>Elementary/Secondary (0-12) 11 T+ College (1-4 or 5+) N/A</i>			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Laborer</i>			16b. Kind of Business/Industry <i>Construction</i>		
	17. Father's Name (First, Middle, Last) <i>John A. Richards</i>			18. Mother's Name (First, Middle, Maiden Surname) <i>ALBERTA Woolly</i>					
	19a. Informant's Name/Relationship (Type, Print) <i>Rolando Richards (Son)</i>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>109 Wheeler Lane Frederick MD 21702</i>					
Physician /Medical Examiner	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <i>GARRISON FOREST Cem. 43-07</i>			20b. Place of Disposition (Name of cemetery, crematory or other place)			Date <i>2007</i>	20c. Location - City or Town, State <i>Owings Mills MD</i>	
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee <i>▶ Gary A. Rollis</i>			22. Name and Address of Facility <i>GARY L. ROLLIS FUNERAL HOME 110 WEST SOUTH ST FREDERICK MD 21701</i>					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <i>ATHRO Sclerosic Coronary ARTERY DISEASE</i>						Approximate Interval Between Onset and Death		
	b. Due to (or as a consequence of): <i>HISTORY OF CVA / STROKE</i>								
	c. Due to (or as a consequence of):								
	d. Due to (or as a consequence of):								
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown			23c. If yes, outcome pf pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <i>9 Unknown</i>			23d. Date of delivery Month Day Year		
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		
							24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
							24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide			28a. Date of Injury (Month, Day Year) <i>M</i> 28b. Time of Injury <i>M</i> 28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No			28d. Describe how injury occurred		
				28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) <i>At home</i>			28f. Location (Street and Number or Rural Route Number, City or Town, State)		
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
	29b. Signature and title of certifier <i>SIBTE A KAZMI, MD</i>			29c. License number <i>D 47951</i>			29d. Date signed (Month, Day, Year) <i>4-2-2007</i>		
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>SIBTE A KAZMI, MD 814 TOLL HOUSE Ave. FREDERICK MD 21701</i>								
State Registrar	31. Date filed (Month, Day, Year) <i>APR 03 2007</i>			32. Registrar's Signature <i>▶ Sean B. Lester</i>					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2007 12284

Reg. No.

1- For
State
RegistrarPhysician
/Medical
ExaminerFuneral
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
 Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit slip.

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) Emerson R. Resh		2. Date of Death Month Day Year March 27 2007	3. Time of Death Hour : Minute 6 : 00 PM
4a. Facility Name (If not institution, give street and number) 600 Light St., Unit 219		4b. City, Town, or Location of Death Baltimore	
4c. County of Death —		5. Social Security Number 213-28-4004	
6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 76 Yrs.	
8. If Under 1 Year Months Days		9. If Under 24 Hrs. Hours Min.	
10a. State MD		10b. County —	
10c. City, Town or Location Baltimore		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number 600 Light St. Apt 219		10f. Zip Code 21230	
10g. Citizen of What Country? USA		11. Usual Residence of Decedent	
12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates Korean War		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: —	
14. Race - American Indian, Black, White, etc. Specify: White		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12	
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Machinist		16b. Kind of Business/Industry Manufacturing	
17. Father's Name (First, Middle, Last) Arthur Resh		18. Mother's Name (First, Middle, Maiden Surname) Elva Grace Yost	
19a. Informant's Name/Relationship (Type, Print) Thomas W. Resh/Son		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7922 Anford Dr., Laurel, MD 20723	
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) Finzel Cemetery		20b. Place of Disposition (Name of cemetery, crematory or other place) Finzel Cemetery	
21. Signature of Funeral Service Licensee ► Dr. Lee Newman		22. Name and Address of Facility Newman Funeral Homes, P.A. P.O. Box 275, Grantsville, MD 21536	
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Atherosclerotic Cardiovascular Disease Sequentially list conditions, Very leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last { a. Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Approximate Interval Between Onset and Death 5 yrs			
23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown	
23d. Date of delivery Month Day Year		23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
23f. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Diabetes Mellitus		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)	
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year) —	
		28b. Time of Injury M	
		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) —		28f. Describe how injury occurred —	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier ► Roberta Dent Jr. MD	
29c. License number D39660		29d. Date signed (Month, Day, Year) March 28, 2007	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Roberta Dent Jr. MD, 707 E. Fort Ave. Baltimore, MD 21230		31. Date filed (Month, Day, Year) APR - 2 2007	
32. Registrar's Signature Robert Dent Jr. MD			

+ VA
State
Registrar

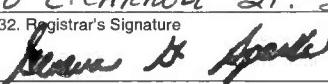
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 12285

1 - For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) RAYMOND WARREN ROBERTS							2. Date of Death Month Day Year MARCH 30 2007	3. Time of Death 1741 M	
	4a. Facility Name (If not institution, give street and number) Peninsula Regional Medical Center			4b. City, Town, or Location of Death Salisbury, Md.			4c. County of Death Wicomico			
Funeral Director	5. Social Security Number 119-01-3090	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 87 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) 2/19/1920	9. Birthplace (State or Foreign Country) New York			
To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State MD 10b. County Worcester 10c. City, Town or Location Pocomoke City								10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	10e. Street and Number 2454 Lakeland Drive			10f. Zip Code 21851			10g. Citizen of What Country? USA			
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: WWII		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: white			14. Race - American Indian, Black, White, etc. Specify: white		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Supervisor			16b. Kind of Business/Industry Airline			
	17. Father's Name (First, Middle, Last) Guy Roberts				18. Mother's Name (First, Middle, Maiden Surname) Martha Eutes					
	19a. Informant's Name/Relationship (Type, Print) Warren Roberts (son)			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2454 Lakeland Dr., Pocomoke City, MD 21851						
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) Pinelawn Cemetery			20b. Place of Disposition (Name of cemetery, crematory or other place) Pinelawn Cemetery		Date 4/4/2007	20c. Location - City or Town, State Farmingdale, NY			
Physician /Medical Examiner	21. Signature of Funeral Service Licensee 			22. Name and Address of Facility Holloway Funeral Home, Professional Association 103 Linden Ave., Pocomoke City, MD 21851						
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) ASCVD			Approximate Interval Between Onset and Death						
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last			a. Due to (or as a consequence of): ASCVD						
				b. Due to (or as a consequence of):						
				c. Due to (or as a consequence of):						
				d. Due to (or as a consequence of):						
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome pf pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown						23d. Date of delivery Month Day Year	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
									24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred				
			28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)				
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								29d. Date signed (Month, Day, Year) 3/30/07	
	29b. Signature and title of certifier 								29c. License number H0057410	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Simona Eng Do 100 E. CARROLL ST. SALISBURY MD 21801								31. Date filed (Month, Day, Year) APR 03 2007	
State Registrar	32. Registrar's Signature 									

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2007 12286

Baltimore, Maryland 21215-0036		Medical Certification: To Be Completed by Physician/Medical Examiner								
<p>Physician /Medical Examiner</p> <p>permits. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.</p> <p>Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.</p>		1. Decedent's Name (First, Middle, Last)				2. Date of Death		3. Time of Death		
		<i>Fred Robert Seville, Sr.</i>				Month	Day	Year	5:58 A M	
<p>Funeral Director</p> <p>To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.</p> <p>To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.</p>		4a. Facility Name (If not institution, give street and number)				4b. City, Town, or Location of Death		4c. County of Death		
		<i>14 Douglas Court West</i>				<i>Smithsburg</i>		<i>Washington</i>		
<p>To Be Completed by Funeral Director</p>		5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	9. Birthplace (State or Foreign Country)		
		<i>214-14-6371</i>	<input checked="" type="checkbox"/> M <input type="checkbox"/> F	94 Yrs.	Months	Days	Hours	Min.	(Month, Day, Year)	<i>Dec. 28, 1912</i>
<p>To Be Completed by Funeral Director</p>		10a. State		10b. County		10c. City, Town or Location				10d. Inside City Limits
		<i>Maryland</i>	<i>Washington</i>		<i>Smithsburg</i>				<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
<p>To Be Completed by Funeral Director</p>		10e. Street and Number				10f. Zip Code		10g. Citizen of What Country?		
		<i>14 Douglas Court West</i>				<i>21783</i>		<i>U.S.A.</i>		
<p>To Be Completed by Funeral Director</p>		11. Marital Status		12. Was Decedent Ever in U.S. Armed Forces?		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)		14. Race - American Indian, Black, White, etc.		
		<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <i>1941-1945</i>	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			
<p>To Be Completed by Funeral Director</p>		15. Decedent's Education (Specify only highest grade completed)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)		16b. Kind of Business/Industry		
		Elementary/Secondary (0-12) <i>7</i>		College (1-4 or 5+)		<i>Driver</i>		<i>State Highway</i>		
<p>To Be Completed by Funeral Director</p>		17. Father's Name (First, Middle, Last)				18. Mother's Name (First, Middle, Maiden Surname)				
		<i>Harvey Seville</i>				<i>Amanda Hull</i>				
<p>To Be Completed by Funeral Director</p>		19a. Informant's Name/Relationship (Type, Print)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)				
		<i>Myrtle M. Seville (Wife)</i>				<i>14 Douglas Crt. West Smithsburg, Maryland 21783</i>				
<p>To Be Completed by Funeral Director</p>		20a. Method of Disposition				20b. Place of Disposition (Name of cemetery, crematory or other place)		Date	20c. Location - City or Town, State	
		<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <i>Jeff Lee Davis Mo1414</i>	<i>Broadfording Bible Bretheren Church Cem.</i>		<i>April 12, 2007</i>	<i>Hagerstown, Maryland</i>				
<p>To Be Completed by Funeral Director</p>		21. Signature of Funeral Service Licensee				22. Name and Address of Facility				
						<i>J.L. Davis Funeral Home 12525 Bradbury Ave. Smithsburg, Maryland 21783</i>				
<p>To Be Completed by Funeral Director</p>		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.								
		<p>Immediate Cause (Final disease or condition resulting in death)</p> <p>a. <i>Cerebrovascular accident</i> Due to (or as a consequence of):</p> <p>b. _____ Due to (or as a consequence of):</p> <p>c. _____ Due to (or as a consequence of):</p> <p>d. _____</p>								
<p>To Be Completed by Funeral Director</p>		IF FEMALE:				23c. If yes, outcome of pregnancy				
		<p>23b. Was decedent pregnant in the past 12 months?</p> <p><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown</p>				<p>23c. If yes, outcome of pregnancy</p> <p><input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown</p> <p>3 <input type="checkbox"/> Ectopic pregnancy 5 <input type="checkbox"/> Other (Specify) _____</p>				
<p>To Be Completed by Funeral Director</p>		23d. Date of delivery								
						Month	Day	Year		
<p>To Be Completed by Funeral Director</p>		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								
		23e. Did tobacco use contribute to the cause of death?								
<p>To Be Completed by Funeral Director</p>						<p>1 <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown</p>				
						<p>24a. Was an autopsy performed?</p> <p><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p>				
<p>To Be Completed by Funeral Director</p>		25. Was case referred to medical examiner?				26. Place of Death (Check only one)				
		<p><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p>				<p>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)</p>				
<p>To Be Completed by Funeral Director</p>		27. Manner of Death				28a. Date of Injury (Month, Day Year)				
		<p><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide</p>				<p>28b. Time of Injury M</p>				
<p>To Be Completed by Funeral Director</p>		28c. Injury at Work?				28d. Describe how injury occurred				
		<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>								
<p>To Be Completed by Funeral Director</p>		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
<p>To Be Completed by Funeral Director</p>		29a. Certifier (Check only one)				29b. Signature and title of certifier				
		<p><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.</p>				<p><i>Maureen Gandy</i></p>				
<p>To Be Completed by Funeral Director</p>		30. Name and address of person who completed use of death (Item 23a) (Type, Print)				29c. License number				
		<i>MANZAR. 3 SHAR. 368 muel st- Hagerstown MD 21740</i>				<i>D28365</i>				
<p>To Be Completed by Funeral Director</p>		31. Date filed (Month, Day, Year)				29d. Date signed (Month, Day, Year)				
		<i>APR 17 2007</i>				<i>4-11-07</i>				
<p>To Be Completed by Funeral Director</p>		32. Registrar's Signature								
		<i>Jan B. Hale</i>								
<p>To Be Completed by Funeral Director</p>		33. Signature of Physician/Medical Examiner								
<p>To Be Completed by Funeral Director</p>		34. Signature of Funeral Director								

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 12287

1 - For State Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Merle Columbus Summers							2. Date of Death Month April Day 9 Year 2007				3. Time of Death 5:09 PM					
	4a. Facility Name (If not institution, give street and number) Frederick Memorial Hospital				4b. City, Town, or Location of Death Frederick				4c. County of Death Frederick								
Funeral Director	5. Social Security Number 215-36-7272	6. Sex 1 X M 2 F	7. Age (In yrs. last birthday) 67 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Hours	8. Date of Birth (Month, Day, Year) July 28, 1939	9. Birthplace (State or Foreign Country) MD										
To Be Completed by Funeral Director	Usual Residence of Decedent		10a. State MD		10b. County Frederick		10c. City, Town or Location Knoxville		10d. Inside City Limits 1 □ Yes 2 X No								
	10e. Street and Number 3855 S. Mountain Rd.				10f. Zip Code 21758				10g. Citizen of What Country? USA								
	11. Marital Status 1 □ Never Married 2 X Married 3 □ Widowed 4 □ Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 X No If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 □ Yes 2 X No Specify:			14. Race - American Indian, Black, White, etc. Specify: White								
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 6				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) carpenter				16b. Kind of Business/Industry general maintenance								
	17. Father's Name (First, Middle, Last) George Summers					18. Mother's Name (First, Middle, Maiden Surname) Ruth Travis											
	19a. Informant's Name/Relationship (Type, Print) Dorothy Summers (Wife)					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3855 S. Mountain Rd., Knoxville, MD 21758											
Physician /Medical Examiner	20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)				20b. Place of Disposition (Name of Facility) Harmony Church of the Brethren Cemetery 413/2007				Date		20c. Location - City or Town, State Myersville, MD						
Medical Certification: To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee <i>Mark B. Hough</i>				22. Name and Address of Facility Donald B. Thompson Funeral Home P. O. Box 18, Middletown, MD 21769												
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Respiratory failure										Approximate Interval Between Onset and Death 20 days						
	<p>a. Due to (or as a consequence of): Pneumonia</p> <p>b. Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. Due to (or as a consequence of):</p>																
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 X No 9 □ Unknown		23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify)								23d. Date of delivery Month Day Year						
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Diabetic ketoacidosis																
	23e. Did tobacco use contribute to the cause of death? 1 □ Yes 2 □ No 3 X Probably 4 □ Unknown																
	24a. Was an autopsy performed? 1 □ Yes 2 X No										24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No						
	25. Was case referred to medical examiner? 1 □ Yes 2 X No		26. Place of Death (Check only one) Hospital: 1 X Inpatient 2 □ ER/Outpatient 3 □ DOA Other: 4 □ Nursing Home 5 □ Residence 6 □ Other (Specify)														
	27. Manner of Death 1 X Natural 5 □ Pending investigation 2 □ Accident 6 □ Could not be determined 3 □ Suicide 4 □ Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury		28c. Injury at Work? M 1 □ Yes 2 □ No		28d. Describe how injury occurred								
			28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State)								
	29a. Certifier (Check only one) 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 □ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.																
	29b. Signature and title of certifier <i>Mark B. Hough M.D.</i>		29c. License number DOO 65049				29d. Date signed (Month, Day, Year) APRIL 11, 2007										
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Hough TAY 400 W. 7th St. FREDERICK, MD 21701																
State Registrar	31. Date filed (Month, Day, Year) APR 17 2007		32. Registrar's Signature <i>Mark B. Hough</i>														

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 3007 12288

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) WESLEY SNOWDEN				2. Date of Death Month 03 Day 25 Year 2007	3. Time of Death 05:55		
	4a Facility Name (If not institution, give street and number) SHADY GROVE ADVENTIST HOSPITAL		4b. City, Town, or Location of Death ROCKVILLE		4c. County of Death MONTGOMERY			
Funeral Director	5. Social Security Number N/A	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. least birthday) Yrs. 74	If Under 1 Year Months 0 Days 0	If Under 24 Hrs. Hours 0 Min. 0	8. Date of Birth (Month, Day, Year) Mar. 25, 2007	9. Birthplace (State or Foreign Country) Maryland	
To Be Completed by Funeral Director	10a. State MD 10b. County Montgomery 10c. City, Town or Location Rockville						10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
	10e. Street and Number 706 Douglas Avenue			10f. Zip Code 20850		10g. Citizen of What Country? U.S.A.		
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: 1941		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: Black		14. Race - American Indian, Black, White, etc. Specify: Black		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) N/A		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (14-or 5+) N/A			16b. Kind of Business/Industry N/A		
	17. Father's Name (First, Middle, Last) James Fletcher Snowden				18. Mother's Name (First, Middle, Maiden Surname) Sharon M. Ramsey			
	19a. Informant's Name/Relationship (Type, Print) James F. Snowden (Father)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 706 Douglas Ave., Rockville, MD 20850					
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) George R. Snowden		20b. Place of Disposition (Name of cemetery, crematory or other place) Riverdale Park Crem		Date 3/31/07	20c. Location - City or Town, State Riverdale, MD		
	21. Signature of Funeral Service Licensee George R. Snowden		22. Name and Address of Facility SNOWDEN FUNERAL HOME, P.A. 246 N. Washington St, Rockville, MD 20850					
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.						Approximate Interval Between Onset and Death	
	a. Extreme Prematurity Due to (or as a consequence of):							
	b. Placenta Abruptio Due to (or as a consequence of):							
	c. _____ Due to (or as a consequence of):							
	d. _____							
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: This law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
							24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred		
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
	29b. Signature and title of certifier STEVE YU, MD				29c. License number D-37776		29d. Date signed (Month, Day, Year) 3/26/07	
	30. Name and address of person who completed cause of death (Item 23e) (Type, Print) STEVE YU, MD, 9901 MEDICAL CENTER DRIVE, ROCKVILLE MARYLAND 20850							
State Registrar	31. Date filed (Month, Day, Year) APR 03 2007		32. Registrar's Signature Steve R. Apone					

ORIGINAL

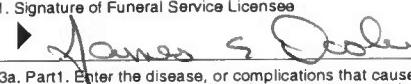
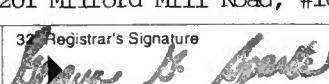
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

1- For
State
Registrar AMEND#20operFH4/4/07, BMW, MoCo

2007 12289
Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Earl Cleveland Simon							2. Date of Death Month Day Year April 1, 2007	3. Time of Death 2258 PM
	4a. Facility Name (If not institution, give street and number) St. Mary's Hospital			4b. City, Town, or Location of Death Leonardtown			4c. County of Death St. Mary's		
Funeral Director	5. Social Security Number 577-12-7746	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 88 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Sept. 13, 1918	9. Birthplace (State or Foreign Country) West Virginia		
	Usual Residence of Decedent 10a. State Maryland			10c. City, Town or Location Charlotte Hall			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
To Be Completed by Funeral Director	10e. Street and Number 29449 Charlotte Hall Road, #B122			10f. Zip Code 20622			10g. Citizen of What Country? USA		
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: WWII			13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: Specify White		14. Race - American Indian, Black, White, etc. Specify White
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Personnel Officer			16b. Kind of Business/Industry Federal Government		
	17. Father's Name (First, Middle, Last) Adlai Simon			18. Mother's Name (First, Middle, Maiden Surname) Eileen Anglin			19a. Informant's Name/Relationship (Type, Print) Sally Ann Price/Daughter		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2847 Schubert Drive, Silver Spring, MD 20904
Physician /Medical Examiner	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) George Washington Cemetery			20b. Place of Disposition (Name of cemetery, crematory or other place) George Washington Cemetery			Date April 3, 2007	20c. Location - City or Town, State Arlington, Maryland	
	21. Signature of Funeral Service Licensee 			22. Name and Address of Facility Francis J. Collins Funeral Home Inc.			23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Myocardial infarction Approximate Interval Between Onset and Death 1 day		
Medical Certification: To Be Completed by Physician/Medical Examiner	23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown			23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year		
	23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide			28a. Date of Injury (Month, Day Year) 10/07	28b. Time of Injury M 1	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred		
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transit slip.	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) At home			28f. Location (Street and Number or Rural Route Number, City or Town, State)					
	29a. Certifier <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.			29c. License number D 52815			29d. Date signed (Month, Day, Year) 4/12/07		
State Registrar	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Donald Alexander, M.D. 201 Milford Mill Road, #105, Baltimore, MD 21208			32. Registrar's Signature 					
	31. Date filed (Month, Day, Year) APR 03 2007								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

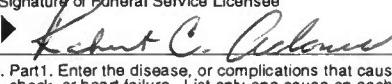
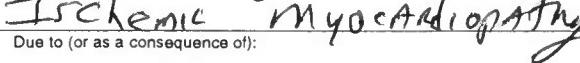
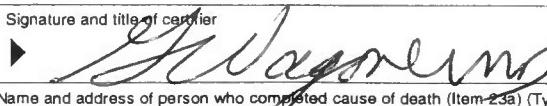
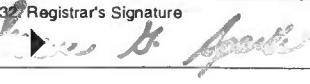
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2007 12290

Reg. No.

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Frederick Donald Dominic Stitcher							2. Date of Death Month Day Year March 31, 2007	3. Time of Death 5:45 P M
	4a. Facility Name (If not institution, give street and number) 14427 Amcelle Street			4b. City, Town, or Location of Death Cresaptown			4c. County of Death Allegany		
Funeral Director	5. Social Security Number 214-05-8660-A	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 89 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) 10/03/1917	9. Birthplace (State or Foreign Country) Maryland		
	Usual Residence of Decedent 10a. State MD 10b. County Allegany 10c. City, Town or Location Cresaptown 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
10e. Street and Number 14427 Amcelle Street				10f. Zip Code 21502			10g. Citizen of What Country? USA		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No 1944- If Yes, Give Year or Dates: 1946		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Sales Representative			16b. Kind of Business/Industry Tobacco		
17. Father's Name (First, Middle, Last) Joseph Frederick Stitcher				18. Mother's Name (First, Middle, Maiden Surname) Nina Ruth Johnson					
19a. Informant's Name/Relationship (Type, Print) Mary S. Grabenstein / daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 932 Weires Avenue, LaVale, Maryland 21502					
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Cumberland Crematory			Date 04/01/2007	20c. Location - City or Town, State Cumberland, MD	
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Adams Family Funeral Home, P.A. 404 Decatur Street, Cumberland, MD 21502					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)				23b. Due to (or as a consequence of):  			Approximate Interval Between Onset and Death 6mos 2yrs		
23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Unknown				23d. Date of delivery Month Day Year					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide				28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred		
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29c. License number D22181			29d. Date signed (Month, Day, Year) April 1, 2007		
29b. Signature and title of certifier 									
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Gary L. Wagener, M.D., 925 Bishop Walsh Drive, Cumberland, MD 21502									
31. Date filed (Month, Day, Year) APR 02 2007				32. Registrar's Signature 					

Baltimore, Maryland 21215-0036

Permit: Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural," or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified. 

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit slip.

Medical Certification: To Be Completed by Physician/Medical Examiner

10/1/04A

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2007 12291
Reg. No.1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) CLARENCE LEWIS SHAW							2. Date of Death Month 3 Day 26 Year 2007	3. Time of Death 8:00 A M
	4a. Facility Name (If not institution, give street and number) & EXT. CARE LIONS CENTER FOR REHABILITATION			4b. City, Town, or Location of Death CUMBERLAND			4c. County of Death ALLEGANY		
Funeral Director	5. Social Security Number 348-01-8146	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 90 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) 7-17-1916	9. Birthplace (State or Foreign Country) ILLINOIS		
To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State MD 10b. County ALLEGANY 10c. City, Town or Location MT. SAVAGE				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				
	10e. Street and Number 12924 ST. GEORGE LANE			10f. Zip Code 21545		10g. Citizen of What Country? UNITED STATES			
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: 1942-1945		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: WHITE		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) MECHANIC			16b. Kind of Business/Industry FIRE COMPANY			
	17. Father's Name (First, Middle, Last) WALTER SHAW				18. Mother's Name (First, Middle, Maiden Surname) THERA JENNINGS SHAW				
	19a. Informant's Name/Relationship (Type, Print) MARTHA SHAW WIFE		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12924 ST. GEORGE LANE MT. SAVAGE, MD 21545			Date	20c. Location - City or Town, State HENDERSONVILLE, TN		
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) WOODLAWN EAST CEMETERY		Date 3-31-2007	20c. Location - City or Town, State FROSTBURG, MD 21532			
	21. Signature of Funeral Service Licensee Alan M. Sowers mo547								
Physician /Medical Examiner	23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Advanced Dementia End stage Approximate Interval Between Onset and Death 6 months								
	23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown								
	23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Unknown								
	23d. Date of delivery Month Day Year								
	23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown								
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
	26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide								
	28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? M <input type="checkbox"/> Yes <input type="checkbox"/> No								
	28d. Describe how injury occurred								
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)								
	28f. Location (Street and Number or Rural Route Number, City or Town, State)								
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
	29b. Signature and title of certifier WONSOCK SHIN MD								
	29c. License number D0055325								
	29d. Date signed (Month, Day, Year) March 26, 2007								
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WONSOCK SHIN MD 48 Tarn Terrace Frostburg MD 21532								
	31. Date filed (Month, Day, Year) MAR 27 2007		32. Registrar's Signature B. Apelt						

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

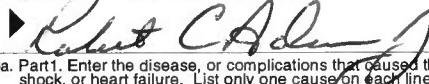
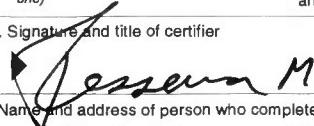
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2007 12292

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) MICHAEL S. SAYKO							2. Date of Death Month 03 Day 19 Year 2007	3. Time of Death 0805PM	
	4a. Facility Name (If not institution, give street and number) WESTERN CORRECTIONAL INSTITUTION			4b. City, Town, or Location of Death CUMBERLAND ALLEGANY			4c. County of Death ALLEGANY			
Funeral Director	5. Social Security Number 111-42-5565		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 56 Yrs.	If Under 1 Year Months 0	If Under 24 Hrs. Days 0	Hours 0	Min. 0	8. Date of Birth (Month, Day, Year) 06/21/1950	9. Birthplace (State or Foreign Country) New York
	10a. State MD		10b. County Allegany	10c. City, Town or Location Cumberland						10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
10e. Street and Number 13800 McMullen Highway					10f. Zip Code 21502			10g. Citizen of What Country? USA		
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No 1967- If Yes, Give Year or Dates: 1970			13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 4 Postal Worker			16b. Kind of Business/Industry U.S. Government				
17. Father's Name (First, Middle, Last) Steven Sayko					18. Mother's Name (First, Middle, Maiden Surname) Margaret Rotolo					
19a. Informant's Name/Relationship (Type, Print) Margaret Sayko / mother					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 404 W. Walnut Street, Rome, New York 13440					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) St. John's Cemetery					Date 03/24/2007	20c. Location - City or Town, State Rome, New York				
21. Signature of Funeral Service Licensee 					22. Name and Address of Facility Adams Family Funeral Home, P.A. 404 Decatur Street, Cumberland, MD 21502					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.					Approximate Interval Between Onset and Death					
a. END STAGE LIVER DISEASE					1 YEAR					
b. HEPATITIS - C CHRONIC INFECTION										
c. Due to (or as a consequence of):										
d. Due to (or as a consequence of):										
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. HISTORY OF ADENO CARCINOMA OF THE LUNG					23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown					
					24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
					24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA			26. Place of Death (Check only one) Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) INFIRmary					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Determined <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury	28c. Injury at Work? M <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred				
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)							28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
29b. Signature and title of certifier  Tessema MD		29c. License number 00055881			29d. Date signed (Month, Day, Year) 03/19/07					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ISAIAH TESSEMA 13800 McMullen Hwy CUMBERLAND, MD. 21502										
31. Date filed (Month, Day, Year) MAR 21 2007		32. Registrar's Signature 								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2007 12293

1- For
State
Registrar

Physician
/Medical
Examiner

Funeral
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

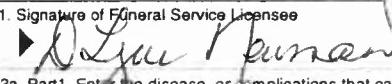
Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 28a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

1. Decedent's Name (First, Middle, Last)	Guy M Sechler			2. Date of Death Month April Day 5 Year 2007	3. Time of Death 6:20 PM
4a. Facility Name (If not institution, give street and number)	Goodwill Mennonite Home			4b. City, Town, or Location of Death Grantsville	4c. County of Death Garrett
5. Social Security Number	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 80 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days Hours Min.	8. Date of Birth (Month, Day, Year) Oct 12, 1926
10a. State PA	10b. County Somerset	10c. City, Town or Location Somerset	9. Birthplace (State or Foreign Country) Pennsylvania		
10e. Street and Number 120 School Bus Road			10f. Zip Code 15501	10g. Citizen of What Country? USA	
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: WW2		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: white
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT USE retired) Dairy Farmer			16b. Kind of Business/Industry Farming
17. Father's Name (First, Middle, Last) Charles E. Sechler			18. Mother's Name (First, Middle, Maiden Surname) Alice T. White		
19a. Informant's Name/Relationship (Type, Print) Nora Sechler/wife			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 120 School Bus Rd., Somerset, PA 15501		
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) New Centerville Union		Date Apr 9, 2007	20c. Location - City or Town, State Rockwood, PA
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Newman Funeral Homes, P.A., P.O. Box 275 179 Miller St., Grantsville, MD 21536			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		Approximate Interval Between Onset and Death 4 days			
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		10 years			
a. Due to (or as a consequence of): acute cerebrovascular accident					
b. Due to (or as a consequence of): cerebrovascular disease					
c. Due to (or as a consequence of):					
d. Due to (or as a consequence of):					
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. diabetes mellitus type two dementia, Alzheimer's type					
24a. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)	28b. Time of Injury M	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29c. License number D0025759			
29b. Signature and title of certifier  MD		29d. Date signed (Month, Day, Year) April 5, 2007			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Walter K. Naumann MD PO Box 247, Accident MD 21520		31. Date filed (Month, Day, Year) APR - 9 2007			
		32. Registrar's Signature 			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 8007 12294

For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Madolyn Isabelle Steinhauser							2. Date of Death Month Day Year March 30, 2007	3. Time of Death 2:45 a M	
	4a. Facility Name (If not institution, give street and number) 6120 Hawthorne Road			4b. City, Town, or Location of Death LaPlata			4c. County of Death Charles			
Funeral Director	5. Social Security Number 215-26-3785	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 77 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days Hours Min.	8. Date of Birth (Month, Day, Year) July 18, 1929	9. Birthplace (State or Foreign Country) Maryland			
	Usual Residence of Decedent 10a. State Maryland			10b. County Charles			10c. City, Town or Location LaPlata			
To Be Completed by Funeral Director	10e. Street and Number 6120 Hawthorne Road			10f. Zip Code 20646			10g. Citizen of What Country? U.S.A.			
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 1		16b. Kind of Business/Industry Manager-Store Keeper					
	17. Father's Name (First, Middle, Last) James M. Cleary, Sr.				18. Mother's Name (First, Middle, Maiden Surname) Nora R. Wright					
	19a. Informant's Name/Relationship (Type, Print) Otto Steinhauser Husband				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6120 Hawthorne Rd., LaPlata, Md. 20646					
	20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) Trinity Memorial Gardens		20b. Place of Disposition (Name of cemetery, crematory or other place) Trinity Memorial Gardens		Date April 3, 2007	20c. Location - City or Town, State Waldorf, Maryland				
Physician /Medical Examiner	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Williams Funeral Home, P.A. 4270 Hawthorne Rd., Indian Head Md.		20640					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				23b. Proximate Interval Between Onset and Death					
	<p>a. cancer of oral cavity Due to (or as a consequence of):</p> <p>b. _____ Due to (or as a consequence of):</p> <p>c. _____ Due to (or as a consequence of):</p> <p>d. _____</p>									
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year					
Medical Certification: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		23f. Describe how injury occurred					
	27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year) March		28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred			
	29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) At home		28f. Location (Street and Number or Rural Route Number, City or Town, State) LaPlata MD 20646					
	29b. Signature and title of certifier 		29c. License number D28352		29d. Date signed (Month, Day, Year) 3/30/07					
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Po Box 1703 LaPlata MD 20646		32. Registrar's Signature 							
State Registrar	31. Date filed (Month, Day, Year) APR 04 2007		32. Registrar's Signature 							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2007 12295

1- For
State
Registrar

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Myrtle Spedden	March 29, 2007	4:31 p M

Funeral
Director

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Chesapeake Woods Center	Cambridge	Dorchester

5. Social Security Number	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 101 Yrs.	If Under 1 Year Months Days Hours Min.	8. Date of Birth (Month, Day, Year) Feb. 3, 1906	9. Birthplace (State or Foreign Country) Maryland
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Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
Maryland	Dorchester	Cambridge	

10e. Street and Number 525 Glenburn Ave.	10f. Zip Code 21613	10g. Citizen of What Country? USA
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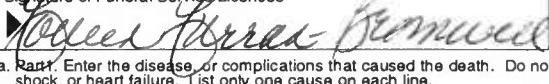
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Specify Yes or No) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	14. Race - American Indian, Black, White, etc. Specify: White
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15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Teacher	16b. Kind of Business/Industry Education
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17. Father's Name (First, Middle, Last) James Franklin Spedden	18. Mother's Name (First, Middle, Maiden Surname) Florence Marshall
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19a. Informant's Name/Relationship (Type, Print) Doris E. McClain/Niece	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5818 Hudson Wharf Rd., Cambridge, MD 21613
--	---

20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)	20b. Place of Disposition (Name of cemetery, crematory or other place) Spedden-Seward Cemetery	Date	20c. Location - City or Town, State 3/31/2007 Cambridge, MD
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21. Signature of Funeral Service Licensee 	22. Name and Address of Facility Curran-Bromwell Funeral Home, P.A. 308 High St., Cambridge, MD 21613
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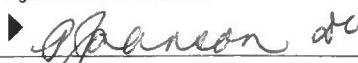
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)	Approximate Interval Between Onset and Death
a. <i>Atherosclerotic cardiovascular disease</i> Due to (or as a consequence of):	
b. <i>Dementia</i> Due to (or as a consequence of):	
c. _____ Due to (or as a consequence of):	
d. _____	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown	23d. Date of delivery Month Day Year
--	---	---

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>HTN, Gastroesophageal reflux disease Glaucoma</i>	23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
--	--

25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide	28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No 28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.	29c. License number H0539978	29d. Date signed (Month, Day, Year) 4/3/07
--	---------------------------------	---

29b. Signature and title of certifier 	29c. License number H0539978	29d. Date signed (Month, Day, Year) 4/3/07
30. Name and Address of person who completed cause of death (Item 23a) (Type, Print) Patricia Johnson 100 Bramble St, Cambridge, MD		

31. Date filed (Month, Day, Year) APR 03 2007	32. Registrar's Signature 
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Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified all.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2007 12296

Reg. No.

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Ruth A. Seward							2. Date of Death Month Day Year March 21 2007	3. Time of Death 8:30A M		
	4a. Facility Name (If not institution, give street and number) 9774 Foy Road			4b. City, Town, or Location of Death Denton			4c. County of Death Caroline				
Funeral Director	5. Social Security Number 213-22-8277	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 80 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) Aug. 1 1926	9. Birthplace (State or Foreign Country) Maryland				
To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State Maryland 10b. County Caroline 10c. City, Town or Location Goldsboro								10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
	10e. Street and Number 211 Old Town Road				10f. Zip Code 21636			10g. Citizen of What Country? U.S.A.			
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 08			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Clerk			16b. Kind of Business/Industry dry cleaning industry				
	17. Father's Name (First, Middle, Last) Noble Bell				18. Mother's Name (First, Middle, Maiden Surname) Lillie May Brown						
	19a. Informant's Name/Relationship (Type, Print) Roy Seward/ son				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 211 Old Town Road; Goldsboro, Maryland 21636						
Physician /Medical Examiner	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Mt. Olive Cemetery			Date 03/25/2007	20c. Location - City or Town, State Felton, Delaware			
Medical Certification: To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee 								22. Name and Address of Facility Fleegle and Helfenbein Funeral Home, PA PO Box 160 Greensboro, Maryland 21639		
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death 24 yrs		
	<p>a. <i>Merkel cell carcinoma - metastatic</i> Due to (or as a consequence of):</p> <p>b. _____ Due to (or as a consequence of):</p> <p>c. _____ Due to (or as a consequence of):</p> <p>d. _____</p>										
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown			23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____ <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year				
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
									24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) HOSPICE HOUSE		
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide			28a. Date of Injury (Month, Day Year)		28b. Time of Injury	28c. Injury at Work? M <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred			
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)								28f. Location (Street and Number or Rural Route Number, City or Town, State)		
	29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								29d. Date signed (Month, Day, Year) 3/24/07		
	29b. Signature and title of certifier 								29c. License number D35284		
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ANDREW REED MD 219 S. Washington St Easton MD 21601										
State Registrar	31. Date filed (Month, Day, Year) MAR 23 2007				32. Registrar's Signature 				ORIGINAL		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001-225

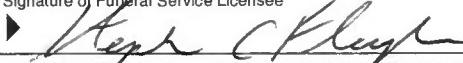
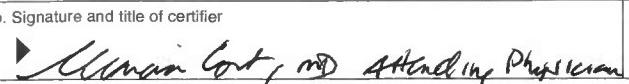
Physician /Medical Examiner		1. Decedent's Name (First, Middle, Last) George H. Smith						2. Date of Death Month Day Year March 19 2007		3. Time of Death 1:32 P M			
Funeral Director		4a. Facility Name (If not institution, give street and number) Caroline Home for Hospice			4b. City, Town, or Location of Death Denton				4c. County of Death Caroline				
To Be Completed by Funeral Director		5. Social Security Number 220-03-6008		6. Sex 1 M 2 F	7. Age (In yrs. last birthday) 84 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	Hours	Min.	8. Date of Birth (Month, Day, Year) June 13 1922	9. Birthplace (State or Foreign Country) Maryland		
		Usual Residence of Decedent		10a. State Maryland		10b. County Caroline		10c. City, Town or Location Greensboro				10d. Inside City Limits 1 Yes 2 No	
		10e. Street and Number 12323 Greensboro Road						10f. Zip Code 21639				10g. Citizen of What Country? U.S.A.	
		11. Marital Status 1 Never Married 2 Married		12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: 1942-45		13. Was Decedent of Hispanic Origin? (Specify Yes or No if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No Specify:				14. Race - American Indian, Black, White, etc. Specify: White			
		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 06		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) mechanic/ self-employed		16b. Kind of Business/Industry auto repair shop							
		17. Father's Name (First, Middle, Last) James Smith				18. Mother's Name (First, Middle, Maiden Surname) Guyla Fortney Smith							
		19a. Informant's Name/Relationship (Type, Print) Agnes Smith/ wife		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12323 Greensboro Road; Greensboro, Maryland 21639									
		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Chesapeake Crem Cn		Date 03/21/2007	20c. Location - City or Town, State Chester, Maryland						
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Fleegle and Helfenbein Funeral Home, PA PO Box 160 Greensboro, MD 21639											
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Colorectal Cancer						Approximate Interval Between Onset and Death Years							
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		a. Due to (or as a consequence of): Colorectal Cancer	b. Due to (or as a consequence of): 	c. Due to (or as a consequence of): 	d. Due to (or as a consequence of): 								
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown		23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown 3 Ectopic pregnancy 5 Other (specify) _____				23d. Date of delivery Month Day Year							
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown							
25. Was case referred to medical examiner? 1 Yes 2 No		26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospice				24a. Was an autopsy performed? 1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No							
27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide		28a. Date of Injury (Month, Day Year) 5 Pending investigation		28b. Time of Injury M	28c. Injury at Work? 1 Yes 2 No	28d. Describe how injury occurred 							
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 				28f. Location (Street and Number or Rural Route Number, City or Town, State) 							
29a. Certifier (Check only one) 1 Certifying Physician 2 Medical Examiner		29b. Signature and title of certifier Stephen E. Muhammad Physician											
29c. License number DOO 52255		29d. Date signed (Month, Day, Year) 03-20-2007											
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Muhammad Eyaaz M.D. 830 Chesapeake Drive Cambridge, MD 21613													
31. Date filed (Month, Day, Year) MAR 20 2007		32. Registrar's Signature B. Barker											
State Registrar													

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene
Certificate of Death

2007 | 2298

1 - For State Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>Carlton Walls Smith, Jr</i>				2. Date of Death Month <input type="text"/> Day <input type="text"/> Year <input type="text"/> <i>March 17 2007</i>	3. Time of Death <input type="text"/> <i>4:12P M</i>			
	4a. Facility Name (If not institution, give street and number) <i>University of Maryland Hospital</i>		4b. City, Town, or Location of Death <i>Baltimore</i>		4c. County of Death <i>Baltimore City</i>				
Funeral Director	5. Social Security Number <input type="text"/> <i>217-44-1689</i>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <input type="text"/> <i>59</i>	If Under 1 Year Months <input type="text"/> Yrs. <input type="text"/>	If Under 24 Hrs. Hours <input type="text"/> Min. <input type="text"/>	8. Date of Birth (Month, Day, Year) <input type="text"/> <i>May 29 1947</i>	9. Birthplace (State or Foreign Country) <input type="text"/> <i>Delaware</i>		
Usual Residence of Decedent							10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
To Be Completed by Funeral Director	10a. State <input type="text"/> <i>Maryland</i>	10b. County <input type="text"/> <i>Caroline</i>	10c. City, Town or Location <i>Goldsboro</i>			10g. Citizen of What Country? <input type="text"/> <i>U.S.A.</i>			
	10e. Street and Number <input type="text"/> <i>15375 Church Lane</i>	10f. Zip Code <input type="text"/> <i>21636</i>							
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <input type="text"/> <i>1970</i>	13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: <input type="text"/> <i>White</i>	14. Race - American Indian, Black, White, etc. Specify: <input type="text"/> <i>White</i>					
	15. Decedent's Education (Specify only highest grade completed) <input type="text"/> <i>Elementary/Secondary (0-12) 12</i>	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <input type="text"/> <i>College (1-4 or 5+) 04 technology manager</i>	16b. Kind of Business/Industry <input type="text"/> <i>Delaware Housing Auth.</i>						
	17. Father's Name (First, Middle, Last) <input type="text"/> <i>Carlton Walls Smith, Sr.</i>	18. Mother's Name (First, Middle, Maiden Surname) <input type="text"/> <i>Eleanor Taylor Smith</i>							
	19a. Informant's Name/Relationship (Type, Print) <input type="text"/> <i>Joan B. Smith; wife</i>	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <input type="text"/> <i>15375 Church Lane; Goldsboro, Maryland 21636</i>							
Physician /Medical Examiner	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <input type="text"/> <i>Chesapeake Crem. Cn.</i>	20b. Place of Disposition (Name of cemetery, crematory or other place) <input type="text"/> <i>Chesapeake Crem. Cn.</i>	Date <input type="text"/> <i>3/20/2007</i>	20c. Location - City or Town, State <input type="text"/> <i>Chester, Maryland</i>					
	21. Signature of Funeral Service Licensee 	22. Name and Address of Facility <input type="text"/> <i>Fleegle and Helfenbein Funeral Home, PA PO Box 160 Greensboro, Maryland 21639</i>							
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <input type="text"/> <i>Hyperensive intracerebral hemorrhage</i>	Approximate Interval Between Onset and Death							
	23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	23c. If yes, outcome pf pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown <input type="checkbox"/> Other (Specify) <input type="text"/> <i>Unknown</i>	23d. Date of delivery Month <input type="text"/> Day <input type="text"/> Year						
Medical Certification: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown				
	25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				23f. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
	27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide	28a. Date of Injury (Month, Day Year) <input type="text"/> <i>March 17, 2007</i>	28b. Time of Injury <input type="text"/> <i>6:08A M</i>	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred <input type="text"/> <i>subject collapsed after attempting to extinguish house fire</i>				
	28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) <input type="text"/> <i>Home</i>	28f. Location (Street and Number or Rural Route Number, City or Town, State) <input type="text"/> <i>15395 Guard Lane Goldsboro MD 21636</i>							
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.	29c. License number <input type="text"/> <i>D0056240</i>				29d. Date signed (Month, Day, Year) <input type="text"/> <i>March 17, 2007</i>			
	29b. Signature and title of certifier 								
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <input type="text"/> <i>Marcia Lott, MD 22-S Greene St, Baltimore MD 21201</i>								
State Registrar	31. Date filed (Month, Day, Year) <input type="text"/> <i>MAR 20 2007</i>	32. Registrar's Signature 							

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

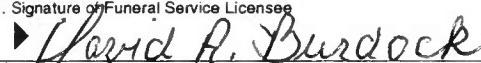
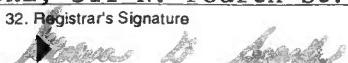
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2007 12299
Reg. No.

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last)					2. Date of Death Month Day Year	3. Time of Death
	Helen Marie Shrout					March 31 2007	4:10 P M
Funeral Director	4a. Facility Name (If not institution, give street and number)			4b. City, Town, or Location of Death		4c. County of Death	
	98 Third Street			Oakland		Garrett	
To Be Completed by Funeral Director	5. Social Security Number		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) Yrs.	If Under 1 Year Months Days Hours Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
	235-52-1791		75			Feb. 5, 1932	West Virginia
Usual Residence of Decedent							
10a. State		10b. County		10c. City, Town or Location			
MD		Garrett		Oakland			
10e. Street and Number				10f. Zip Code		10g. Citizen of What Country?	
98 Third Street				21550		United States	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Clerk			16b. Kind of Business/Industry Assessors Office		
17. Father's Name (First, Middle, Last)				18. Mother's Name (First, Middle, Maiden Surname)			
Harold J. Taylor				Della Stevenson			
19a. Informant's Name/Relationship (Type, Print)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)			
Denise Kisselovich, Daughter				P.O. Box 123, Oakland, MD 21550			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) 12		20b. Place of Disposition (Name of cemetery, crematory or other place)		Date		20c. Location - City or Town, State	
		Garrett Memorial Gardens 4/6/07		Oakland, MD			
21. Signature of Funeral Service Licensee 							
22. Name and Address of Facility David A. Burdock Funeral Home, P.A. 21 N. Second St., Oakland, MD 21550							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Lung Cavewoma							
Approximate Interval Between Onset and Death 6 mo							
23b. Part II. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							
23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Unknown							
23d. Date of delivery Month Day Year							
24e. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown							
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide							
28a. Date of Injury (Month, Day Year)		28b. Time of Injury		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)							
28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
29b. Signature and title of certifier 				29c. License number		29d. Date signed (Month, Day, Year) 4/2/07	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)							
Dr. Robert A. Goralski, 311 N. Fourth St., Oakland, MD 21550							
31. Date filed (Month, Day, Year) APR - 3 2007		32. Registrar's Signature 					

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2007 12300

Certificate of Death

Reg. No.

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Dewey Dustin Thompson							2. Date of Death Month Day Year March 31 2007	3. Time of Death 11:20a^M		
	4a. Facility Name (If not institution, give street and number) 225 Frock Drive			4b. City, Town, or Location of Death Westminster			4c. County of Death Carroll				
Funeral Director	5. Social Security Number 216-18-1153	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 86 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) Feb 01 1921	9. Birthplace (State or Foreign Country) MD				
To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State MD 10b. County Carroll 10c. City, Town or Location Westminster 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										
	10e. Street and Number 225 Frock Drive Apt. 143			10f. Zip Code 21157			10g. Citizen of What Country? USA				
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: 1942 1945	13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	14. Race - American Indian, Black, White, etc. Specify: White							
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Custodian			16b. Kind of Business/Industry Board of Education					
	17. Father's Name (First, Middle, Last) Fay Thompson				18. Mother's Name (First, Middle, Maiden Surname) Susie Perdew						
	19a. Informant's Name/Relationship (Type, Print) Martha Kay Thompson/wife					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 225 Frock Drive Westminster, MD 21157					
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <i>Carroll Cremation, Inc</i>		20b. Place of Disposition (Name of cemetery, crematory or other place) Carroll Cremation, Inc		20c. Date of Disposition 04/03/2007		20c. Location - City or Town, State Hampstead, MD				
	21. Signature of Funeral Service Licensee <i>John R. Ales</i>										
	22. Name and Address of Facility Pitts Funeral Home and Chapel, P.A. 412 Washington Road Westminster, MD 21157										
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Dementia a. Due to (or as a consequence of): Peripheral Vascular Disease b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):								Approximate Interval Between Onset and Death		
	23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year					
Medical Certification; To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Chronic Kidney Disease DM Type 2 HTN								23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			23f. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred				
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)								
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
	29b. Signature and title of certifier <i>L</i>		29c. License number D56508			29d. Date signed (Month, Day, Year) April 2, 2007					
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3900 LOCH RAVEN BLVD., BALTIMORE, MD 21218		32. Registrar's Signature <i>Xiangrong Shao</i>								
	31. Date filed (Month, Day, Year) APR 03 2007		32. Registrar's Signature <i>Xiangrong Shao</i>								

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial/transitance.

Medical Certification; To Be Completed by Physician/Medical Examiner

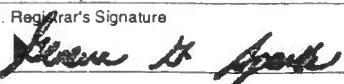
Permit: Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2007 12301

1- For State Registrar		2. Date of Death Month Day Year March 31, 2007		3. Time of Death 11:45 P M		
Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) NELLIE VIRGINIA THOMAS		4. Facility Name (If not institution, give street and number) Alice Byrd Tawes Nursing Home			
Funeral Director	4a. Facility Name (If not institution, give street and number) Alice Byrd Tawes Nursing Home		4b. City, Town, or Location of Death Crisfield			
To Be Completed by Funeral Director	4c. County of Death Somerset					
	5. Social Security Number 212-26-7999	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 100 Yrs.	If Under 1 Year Months Days Hours Min. If Under 24 Hrs. Hours Min.		
				8. Date of Birth (Month, Day, Year) March 22, 1907	9. Birthplace (State or Foreign Country) Maryland	
	Usual Residence of Decedent 10a. State Maryland		10b. County Somerset		10c. City, Town or Location Crisfield	
	10e. Street and Number 35 Somers Cove Apartments		10f. Zip Code 21817		10g. Citizen of What Country? USA	
To Be Completed by Physician/Medical Examiner	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: 7	13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: White	14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+)	16b. Kind of Business/Industry Worker		
	17. Father's Name (First, Middle, Last) Clarence Johnson		18. Mother's Name (First, Middle, Maiden Surname) Margaret Hill			
	19a. Informant's Name/Relationship (Type, Print) Gladys M. Adkins (Daughter)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 35 Somers Cove Apartments - Crisfield, MD 21817			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) Mary Beth Bradshaw-Pruitt		20b. Place of Disposition (Name of cemetery, crematory or other place) Asbury Cemetery	Date 4/3/2007	20c. Location - City or Town, State Crisfield, Maryland	
	21. Signature of Funeral Service Licensee Mary Beth Bradshaw-Pruitt		22. Name and Address of Facility Bradshaw & Sons Funeral Home 306 W. Main St. - Crisfield, MD 21817			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last					
	<p>a. Due to (or as a consequence of): ASCVD</p> <p>b. Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. Due to (or as a consequence of):</p>					
	23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					
	23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown					
	<p>24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>					
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
	<p>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)</p> <p>26. Place of Death (Check only one) <input checked="" type="checkbox"/> Nursing Home</p>					
	<p>27. Manner of Death 1 <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide <input type="checkbox"/> Determined 4 <input type="checkbox"/> Homicide</p> <p>28a. Date of Injury (Month, Day, Year) 28b. Time of Injury M 28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>28d. Describe how injury occurred</p>					
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					
	28f. Location (Street and Number or Rural Route Number, City or Town, State)					
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
	29b. Signature and title of certifier 					
	29c. License number D 48098					
	29d. Date signed (Month, Day, Year) 4/2/2007					
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Vijay Karumbunathan, M.D. - 201 Hall Highway - Crisfield, MD 21817					
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit document.	31. Date filed (Month, Day, Year) APR 03 2007					
	32. Registrar's Signature 					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2007 12302

1- For
State
RegistrarPhysician
/Medical
ExaminerFuneral
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
 Important: If item 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year		3. Time of Death
MARY ERMA THOMPSON		APRIL 1, 2007		9:24 P M
4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of Death		4c. County of Death
21725 ST. LO PLACE		LEXINGTON PARK		ST. MARY'S
5. Social Security Number		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) Yrs.	If Under 1 Year Months Days Hours Min.
217-32-4238			71	
10a. State MD		10b. County ST. MARY'S	10c. City, Town or Location LEXINGTON PARK	
10e. Street and Number 21725 ST. LO PLACE		10f. Zip Code 20653		10g. Citizen of What Country? UNITED STATES
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 7		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) CAREGIVER		16b. Kind of Business/Industry HEALTH CARE
17. Father's Name (First, Middle, Last) GEORGE SOMERSET THOMPSON		18. Mother's Name (First, Middle, Maiden Surname) MARGURITA SWANN THOMPSON		
19a. Informant's Name/Relationship (Type, Print) BRENDA THOMAS/DAUGHTER		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5318 HOLLY STREET, INDIAN HEAD, MARYLAND 20640		
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) ST. CHARLES CEMETERY		20b. Place of Disposition (Name of cemetery, crematory or other place) Date 4/7/2007		20c. Location - City or Town, State GLYMONT, MARYLAND
21. Signature of Funeral Service Licensee LYDIA C. THORNTON JOHNSON		22. Mailing Address of Facility THORNTON FUNERAL HOME, P.A. 3439 LIVINGSTON ROAD, INDIAN HEAD, MD 20640		
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		Lung Cancer		Approximate Interval Between Onset and Death 11 months
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				
a. Due to (or as a consequence of):				
b. Due to (or as a consequence of):				
c. Due to (or as a consequence of):				
d. Due to (or as a consequence of):				
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome pf pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____		23d. Date of delivery Month Day Year
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
				24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No
				28d. Describe how injury occurred
				28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)
29a. Certifier (Check only one)		29b. Signature and title of certifier Patrick Cross, MD		29c. License number D00 41728
				29d. Date signed (Month, Day, Year) 4-4-07
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)		PATRICK CROSS, MD 25500 POINT LOOKOUT ROAD LEONARDTOWN, MARYLAND 20650		
31. Date filed (Month, Day, Year) APR 04 2007		32. Registrar's Signature Karen A. Jones		

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 12303

1 - For State Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Mildred Patricia Thomas							2. Date of Death Month Day Year April 1, 2007	3. Time of Death 1530 M	
	4a. Facility Name (If not institution, give street and number) SALISBURY REHAB & NURSING CENTER			4b. City, Town, or Location of Death SALISBURY, MD. 21804			4c. County of Death WICOMICO			
Funeral Director	5. Social Security Number 069-07-2154	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 97 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) Aug. 15, 1909	9. Birthplace (State or Foreign Country) New York			
To Be Completed by Funeral Director	10a. State MD			10b. County Wicomico			10c. City, Town or Location Salisbury		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	10e. Street and Number 5490 King Stuart Drive				10f. Zip Code 21801			10g. Citizen of What Country? USA		
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: 11		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: White			14. Race - American Indian, Black, White, etc. Specify:		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Inspector			16b. Kind of Business/Industry Carpet Company			
	17. Father's Name (First, Middle, Last) Thomas Varsoke					18. Mother's Name (First, Middle, Maiden Surname) Johanna Savage				
	19a. Informant's Name/Relationship (Type, Print) Cynthia T. Merrick daughter			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5490 King Stuart Drive, Salisbury, MD 21801						
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) Burial			20b. Place of Disposition (Name of cemetery, crematory, other place) Our Lady of Good Counsel Cemetery			Date 4/4/2007	20c. Location - City or Town, State Secretary, MD		
	21. Signature of Funeral Service Licensee B. L. B.			22. Name and Address of Facility Thomas Funeral Home, P.A.			700 Locust St. Cambridge, MD 21613			
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last									
	<p>a. <i>Alzheimer Disease</i> years</p> <p>b. <i>Hypertension</i> years</p> <p>c. _____</p> <p>d. _____</p>									
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown			23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year			
Medical Certification: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									
	23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown									
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide			28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred		
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
	29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.			29b. Signature and title of certifier 						
				29c. License number 229349			29d. Date signed (Month, Day, Year) 8/2/07			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WILLIAM ROBINS, M.D. 200 CIVIC AVE., SALISBURY, MD. 21804									
State Registrar	31. Date filed (Month, Day, Year) APR 03 2007		32. Registrar's Signature 							

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit slip.

Permit: Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

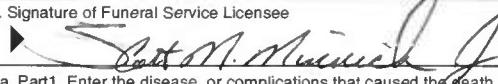
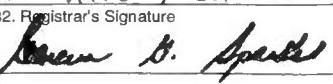
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 12304

1- For State Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Elsie Lidia THOMAS						2. Date of Death Month April Day 2 Year 2007	3. Time of Death 2:00 p.m.
	4a. Facility Name (If not institution, give street and number) Charlotte's Home			4b. City, Town, or Location of Death Maugansville			4c. County of Death Washington	
Funeral Director	5. Social Security Number 140-24-4036	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 73 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	B. Date of Birth (Month, Day, Year) Dec. 13, 1933	9. Birthplace (State or Foreign Country) New Jersey	
	Usual Residence of Decedent 10a. State Maryland			10b. County Washington			10c. City, Town or Location Hagerstown	
10e. Street and Number 13827 Cearfoss Pike				10f. Zip Code 21740			10g. Citizen of What Country? United States	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: white			14. Race - American Indian, Black, White, etc. Specify:	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) unknown		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) homemaker		16b. Kind of Business/Industry her own home				
17. Father's Name (First, Middle, Last) Levi Turner				18. Mother's Name (First, Middle, Maiden Surname) Augusta unknown				
19a. Informant's Name/Relationship (Type, Print) Donna Delauter daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 356 Woodpoint Avenue, Hagerstown, Maryland 21740				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Cedar Lawn Mem. Park			Date 4/10/07	20c. Location - City or Town, State Hagerstown, Maryland		
21. Signature of Funeral Service Licensee 								
22. Name and Address of Facility Minnich Funeral Home 415 E. Wilson Blvd., Hagerstown, Maryland 21740								
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Laryngeal Cancer Approximate Interval Between Onset and Death 1 year								
23b. Part II. Enter conditions, if any, leading to immediate cause. Enter 1 underlying cause (Disease or injury that initiated events resulting in death) Last Sequentially list conditions, if any, leading to immediate cause. Enter 1 underlying cause (Disease or injury that initiated events resulting in death) Last {								
a. Due to (or as a consequence of): Laryngeal Cancer								
b. Due to (or as a consequence of):								
c. Due to (or as a consequence of):								
d. Due to (or as a consequence of):								
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome pf pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								
23e. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown								
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) Assisted living								
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred Living		
28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)								
28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier 		29c. License number 041667			29d. Date signed (Month, Day, Year) 4.4.07			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Michael McCormack 1110 Medical Campus Hagerstown MD 21742								
31. Date filed (Month, Day, Year) APR 04 2007		32. Registrar's Signature 						

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

SH-4

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 12305

1- For State Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Walter William Edward Tritthart, Jr.							2. Date of Death Month March Day 29 , Year 2007	3. Time of Death 2:53 A M
	4a. Facility Name (If not institution, give street and number) Caroline Home for Hospice				4b. City, Town, or Location of Death Denton			4c. County of Death Caroline	
Funeral Director	5. Social Security Number 154-34-0181	6. Sex 1 X M 2 F	7. Age (In yrs. last birthday) 63 Yrs.	If Under 1 Year Months Jan 13	If Under 24 Hrs. Hours 1944	Min.	8. Date of Birth (Month, Day, Year) 1944	9. Birthplace (State or Foreign Country) New York	
	Usual Residence of Decedent 10a. State Maryland 10b. County Caroline				10c. City, Town or Location Greensboro			10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 X No	
To Be Completed by Funeral Director	10e. Street and Number 12306 Greensboro Road			10f. Zip Code 21639			10g. Citizen of What Country? U.S.A.		
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: 1962-66		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: White			14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 04 accountant		16b. Kind of Business/Industry building industry				
	17. Father's Name (First, Middle, Last) Walter William Edward Tritthart, Sr.				18. Mother's Name (First, Middle, Maiden Surname) Letha Armstrong				
Physician /Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Norma Linguito/ sister			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14 Briar Wood Road; Jersey City, New Jersey 07305					
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) Chesapeake Cremation			20b. Place of Disposition (Name of cemetery, crematory or other place) Chesapeake Cremation			Date 04/03/2007	20c. Location - City or Town, State Chester, Maryland	
Medical Certification: To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee Stephen C. Flynn			22. Name and Address of Facility Fleegle and Helfenbein Funeral Home, PA PO Box 160; Greensboro, Maryland 21639					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)			Approximate Interval Between Onset and Death					
<p>a. CIRRHOSIS Due to (or as a consequence of):</p> <p>b. HEPATITIS B, CHRONIC Due to (or as a consequence of):</p> <p>c. _____ Due to (or as a consequence of):</p> <p>d. _____</p>									
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 X No 9 <input type="checkbox"/> Unknown			23c. If yes, outcome pf pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown						
23d. Date of delivery Month Day Year									
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. LIVER MASS			23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown						
			24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 X No						
			24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No						
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 X No			26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) HOSPICE						
27. Manner of Death 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide			28a. Date of Injury (Month, Day Year) 28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		
5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined			28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
29b. Signature and title of certifier Stephen R. Allo, M.D.			29c. License number D63063			29d. Date signed (Month, Day, Year) MARCH 29 2007			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) STEPHEN R. ALLO, M.D. 609 Daffin Lane DENTON, MARYLAND 21629									
31. Date filed (Month, Day, Year) MAR 29 2007			32. Registrar's Signature Stephanie R. Allo, M.D.						

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 12306

1 - For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Mildred C. Todd							2. Date of Death Month Day Year March 25, 2007	3. Time of Death 12:58 pM
	4a. Facility Name (If not institution, give street and number) Caroline Home for Hospice				4b. City, Town, or Location of Death Denton			4c. County of Death Caroline	
Funeral Director	5. Social Security Number 213-22-2585	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 80 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) Mar. 8, 1927	9. Birthplace (State or Foreign Country) Maryland		
Usual Residence of Decedent									
	10a. State MD	10b. County Caroline	10c. City, Town or Location Federalsburg					10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number 25612 Auction Road				10f. Zip Code 21632			10g. Citizen of What Country? United States		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Homemaker				16b. Kind of Business/Industry Own Home	
17. Father's Name (First, Middle, Last) William A. Cox					18. Mother's Name (First, Middle, Maiden Surname) Grace E. Andrew				
19a. Informant's Name/Relationship (Type, Print) John W. Todd / Son		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 23926 Wilkins Branch Rd., Preston, MD 21655							
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Hillcrest Cemetery			Date 03/31/07	20c. Location - City or Town, State Federalsburg, MD		
21. Signature of Funeral Service Licensee Michael T. Askow				22. Name and Address of Facility Frampton Funeral Home, P.A. 216 N. Main St., Federalsburg, MD 21632					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.									
Immediate Cause (Final disease or condition resulting in death) Congestive heart failure Approximate Interval Between Onset and Death 5 months									
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last									
<p>a. Congestive heart failure Due to (or as a consequence of):</p> <p>b. Chronic obstructive pulmonary Due to (or as a consequence of): several years</p> <p>c. Due to (or as a consequence of):</p> <p>d. Due to (or as a consequence of):</p>									
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown						23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									
23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown									
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)							
29b. Signature and title of certifier Matthew Fischer		29c. License number D5 2251				29d. Date signed (Month, Day, Year) 3/29/07			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Matthew Fischer 2 Martin Court Suite 1 Easton Maryland 21601									
31. Date filed (Month, Day, Year) Mar 30 2007					32. Registrar's Signature Leanne B. Fischer				

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28e-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit

Medical Certification; To Be Completed by Physician/Medical Examiner

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State
Registrar

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene
1- For Amend #8 Per FH G867 5/14/01 OR Certificate of Death Reg. No. 2007 12307

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Charlotte Todd						2. Date of Death Month Day Year March 15 2007	3. Time of Death 10:00 P M								
	4a. Facility Name (If not institution, give street and number) Candle Light Cove			4b. City, Town, or Location of Death Easton			4c. County of Death Talbot									
Funeral Director	5. Social Security Number 219-03-1370						6. Sex M	7. Age (In yrs. last birthday) 89 Yrs.	If Under 1 Year Months 0	If Under 24 Hrs. Days 0	Hours 0	Min. 0	8. Date of Birth (Month, Day, Year) May 6, 1919	9. Birthplace (State or Foreign Country) Maryland		
To Be Completed by Funeral Director	10a. State MD						10b. County Talbot	10c. City, Town or Location Easton						10d. Inside City Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
	10e. Street and Number 700 Port Street						10f. Zip Code 21601			10g. Citizen of What Country? USA						
	11. Marital Status Never Married		12. Was Decedent Ever in U.S. Armed Forces? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> If Yes, Give Year or Dates: 1971			13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Specify: Caucasian			14. Race - American Indian, Black, White, etc.							
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Business person			16b. Kind of Business/Industry Manufacturing/retail										
	17. Father's Name (First, Middle, Last) Philip McGovern Golden						18. Mother's Name (First, Middle, Maiden Surname) Charlotte Eliza Huffman									
	19a. Informant's Name/Relationship (Type, Print) John K. Todd, Sr. / husband						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 700 Port St., Apt. 322, Easton, MD 21601									
Physician /Medical Examiner	20a. Method of Disposition Burial <input type="checkbox"/> Cremation <input checked="" type="checkbox"/> Removal from State Donation <input type="checkbox"/> Other (Specify)						20b. Place of Disposition (Name of cemetery, crematory or other place) Capitol Crematory			Date 3/17/2007		20c. Location - City or Town, State Dover, DE				
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee Randolph Moore						22. Name and Address of Facility Moore Funeral Home, P.A. 72 South Second Street, Denton, Maryland 21629									
	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)						Approximate Interval Between Onset and Death 3 years									
	a. Due to (or as a consequence of): Alzheimer's disease															
	b. Due to (or as a consequence of):															
	c. Due to (or as a consequence of):															
	d. _____															
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Unknown						23c. If yes, outcome of pregnancy Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown <input type="checkbox"/>						23d. Date of delivery Month Day Year			
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23e. Did tobacco use contribute to the cause of death? Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown <input checked="" type="checkbox"/>									
	25. Was case referred to medical examiner? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>						26. Place of Death (Check only one) Hospital: Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA <input type="checkbox"/> Other: Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)									
	27. Manner of Death Natural <input checked="" type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/>						28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		28d. Describe how injury occurred			
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State)									
	29a. Certifier (Check only one) Certifying Physician : To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner : On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.						29c. License number 0005132						29d. Date signed (Month, Day, Year) March 16, 2007			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jorge Abrego, M.D., 598 Cunwood Drive, Easton, Maryland 21601															
	31. Date filed (Month, Day, Year) MAR 20 2007						32. Registrar's Signature Jeanne L. Brown									

Baltimore, Maryland 21215-0036

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or items 23a or 23c show any injury or other traumatic event, the Medical Examiner must be notified.

Division of Vital Records, P.O. Box 68760,

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene
Certificate of Death

Reg. No.

2007 12308

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Paul Valentine							2. Date of Death Month 4 Day 1 Year 2007			3. Time of Death 12:28 PM				
	4a. Facility Name (If not institution, give street and number) Peninsula Regional Medical Center			4b. City, Town, or Location of Death Salisbury			4c. County of Death Wicomico								
Funeral Director	5. Social Security Number 221-22-8125							6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 69 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	24 Hrs. Hours	Min.	8. Date of Birth (Month, Day, Year) Dec. 30, 1937	9. Birthplace (State or Foreign Country) Wilmington, DE
To Be Completed by Funeral Director	10a. State DE							10b. County Sussex	10c. City, Town or Location Dagsboro					10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	10e. Street and Number 30874 Peppers Creek Road				10f. Zip Code 19939				10g. Citizen of What Country? USA						
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: white						
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) carpenter			16b. Kind of Business/Industry Richard S. DuPont Est.								
	17. Father's Name (First, Middle, Last) Paul Valentine, Sr.					18. Mother's Name (First, Middle, Maiden Surname) Emma Campbell									
	19a. Informant's Name/Relationship (Type, Print) Joyce Valentine (wife)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 30874 Peppers Creek Rd. Dagsboro, DE 19939										
Physician /Medical Examiner	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Gracelawn Mem. Pk			Date April 5, 2007	20c. Location - City or Town, State New Castle, DE							
	21. Signature of Funeral Service Licensee Murphy J. Carroll m60788			22. Name and Address of Facility McCrery Funeral Homes, Inc. 3924 Concord Pike Wilmington, DE 19803											
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) CARDIAC ARREST Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last CORONARY ARTERY DISEASE										Approximate Interval Between Onset and Death				
	a. Due to (or as a consequence of): CARDIAC ARREST b. Due to (or as a consequence of): CORONARY ARTERY DISEASE c. Due to (or as a consequence of): d. Due to (or as a consequence of):														
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown			23c. If yes, outcome pf pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____ <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year								
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. HYPERLIPIDIMIA										23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown				
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify)			24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide			28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred							
				28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)					28f. Location (Street and Number or Rural Route Number, City or Town, State)						
	29a. Certifier (Check only one) Medical Examiner			29b. Signature and title of certifier PRAKASH R DALAL, MD			29c. License number D43522	29d. Date signed (Month, Day, Year) 4/1/07							
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PRAKASH R DALAL, MD 614 Eastern Shore Drive, Salisbury, MD 21801														
State Registrar	31. Date filed (Month, Day, Year) APR 4 2007		32. Registrar's Signature Leanne M. Speer												

Paul Valentine 900-30-9462
Division or Vital Records, P.O. Box 68760,To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transitBaltimore, Maryland 21215-0036
Permit, Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

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State of Maryland / Department of Health and Mental Hygiene

Amend #8 Per EH G866 4/17/07 Jn

Certificate of Death

Reg. No. 2007 12309

1- For
State
Registrar

Physician
/Medical
Examiner

Funeral
Director

To Be Completed by Funeral Director

Wilson, Ruth T.

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit once.

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year		3. Time of Death
RUTH T. WILSON		April 8, 2007		7:51 PM
4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of Death		4c. County of Death
LIONS MANOR NURSING HOME		CUMBERLAND		ALLEGANY
5. Social Security Number		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 99 Yrs.	If Under 1 Year Months Days Hours Min.
218-30-0599				
8. Date of Birth (Month, Day, Year)		9. Birthplace (State or Foreign Country)		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
MAR DEC 16 1907		PENNSYLVANIA		
Usual Residence of Decedent				
10a. State MD	10b. County ALLEGANY	10c. City, Town or Location LAVALE		
10e. Street and Number 101 LONG DRIVE			10f. Zip Code 21502	10g. Citizen of What Country? USA
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: Specify: WHITE	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) TEACHER	16b. Kind of Business/Industry EDUCATION	
17. Father's Name (First, Middle, Last) CHARLES HUNTER			18. Mother's Name (First, Middle, Maiden Surname) NELLE (SHANK) HUNTER	
19a. Informant's Name/Relationship (Type, Print) SARA SALLY J. BARMONY daughter		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 546 N FIRST ST., LAVALE, MD 21502		
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) REST LAWN MEM PARK	Date APR 13 07	20c. Location - City or Town, State LAVALE, MD
21. Signature of Funeral Service Licensee ► John J. Jotaffer, Jr.		22. Name and Address of Facility HAFER FUNERAL SERVICE, PA 1302 NATIONAL HWY., LAVALE, MD 21502		
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		Approximate Interval Between Onset and Death YRS		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		a. <i>Arteriosclerotic Cardiovascular Disease</i> Due to (or as a consequence of):	YRS	
		b. <i>Hypertension</i> Due to (or as a consequence of):		
		c. _____ Due to (or as a consequence of):		
		d. _____		
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome pf pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) _____	23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. SMOKER				
23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown				
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> COA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
		28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29b. Signature and title of certifier ► B. J. K.		29c. License number # D42054		29d. Date signed (Month, Day, Year) April 10, 2007
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Gregg Donaldson, M.D. 912 Seton Drive Cumberland, MD 21502				
31. Date filed (Month, Day, Year) APR 17 2007		32. Registrar's Signature Barbara B. J. K.		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2007 12310

Certificate of Death

Reg. No.

1 - For State Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Susan Michelle West						2. Date of Death Month Day Year April 2, 2007	3. Time of Death 11:10 AM
	4a. Facility Name (If not institution, give street and number) 1 Cherry Manor Court			4b. City, Town, or Location of Death Reisterstown		4c. County of Death Baltimore		
Funeral Director	5. Social Security Number 218-80-4865	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 48 Yrs.	If Under 1 Year Months Days Hours Min.	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month Day Year) 01/04/1959	9. Birthplace (State or Foreign Country) New Jersey	
To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State MD 10b. County Baltimore 10c. City, Town or Location Reisterstown 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
	10e. Street and Number 1 Cherry Manor Court			10f. Zip Code 21136		10g. Citizen of What Country? United States		
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 7		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker			16b. Kind of Business/Industry Own Home		
	17. Father's Name (First, Middle, Last) Pearlie Russell Sellars			18. Mother's Name (First, Middle, Maiden Surname) Mary Ann Lennon				
	19a. Informant's Name/Relationship (Type, Print) Eileen Jarava/ Sister			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 Cherry Manor Ct., Reisterstown, MD 21136				
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Carroll Cremation		Date 4/4/2007	20c. Location - City or Town, State Hampstead, MD	
Physician /Medical Examiner	21. Signature of Funeral Service Licensee ► Steven W. Eline M00723			22. Name and Address of Facility Eline Funeral Home 934 S. Main St., Hampstead, MD 21074				
	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of): Rheumatoid Arthritis Approximate Interval Between Onset and Death 1 yr. b. Due to (or as a consequence of): WTIV M ETS c. Due to (or as a consequence of): d. Due to (or as a consequence of):							
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown			23c. If yes, outcome pf pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) 9/Unknown			23d. Date of delivery Month Day Year	
Medical Certification: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. COPD, Brown cancer							
	23e. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown							
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
	27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year) 28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred	
	28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)					
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
	29b. Signature and title of certifier ► Simon Scalin m.d.		29c. License number D 24276		29d. Date signed (Month, Day, Year) 4-3-07			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Simon Scalin m.d. 2801 HUDSON ST BALTO. MD 21224							
State Registrar	31. Date filed (Month, Day, Year) APR 03 2007		32. Registrar's Signature Steven W. Eline					

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
 Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

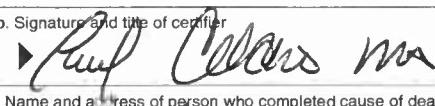
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 12311

1 - For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Maria Nancy Workman					2. Date of Death Month 3 Day 31 Year 2007	3. Time of Death 10:40 A.M.
	4a. Facility Name (If not institution, give street and number) 4904 Grave Run Road			4b. City, Town, or Location of Death Manchester		4c. County of Death Carroll	
Funeral Director	5. Social Security Number 184-52-4870	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) Yrs. 50	If Under 1 Year Months	If Under 24 Hrs. Days Hours Min.	8. Date of Birth (Month, Day, Year) 10/26/1956	9. Birthplace (State or Foreign Country) Pennsylvania
	10a. State MD 10b. County Carroll 10c. City, Town or Location Manchester					10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number 4904 Grave Run Road				10f. Zip Code 21102		10g. Citizen of What Country? United States	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Homemaker			16b. Kind of Business/Industry Residence	
17. Father's Name (First, Middle, Last) Vincent Nicholas Argiro, Sr.				18. Mother's Name (First, Middle, Maiden Surname) Louise Francesca Petrucci			
19a. Informant's Name/Relationship (Type, Print) Husband William McCullough Workman III.			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4904 Grave Run Road Manchester, Maryland 21102			Date 4/5/2007	20c. Location - City or Town, State Upperco, Maryland
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Grace U. M. Cemet.					
21. Signature of Funeral Service Licensee 			22. Name and Address of Facility Eline Funeral Home, 934 South Main Street Hampstead, Maryland 21074				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Breast Cancer							
Approximate Interval Between Onset and Death 9 years and 6 months							
23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown							
23c. If yes, outcome pf pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Unknown							
23d. Date of delivery Month Day Year							
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown							
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred	
28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
29b. Signature and title of certifier 		29c. License number D36929		29d. Date signed (Month, Day, Year) April 2, 2007			
31. Date filed (Month, Day, Year) APR 02 2007		32. Registrar's Signature 					

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit once.

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
 Important: If Item 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

WJL
6

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2007 12312

1- For
State
RegistrarPhysician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death				3. Time of Death		
	Nan Mintz Wrang		Month	Day	Year	1:24p M	
217 West Main St.		Elkton			Cecil		
4. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of Death			4c. County of Death		
5. Social Security Number		6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year	8. Date of Birth	9. Birthplace (State or Foreign Country)	
420-30-9802		<input type="checkbox"/> M <input checked="" type="checkbox"/> F	77 Yrs.	Months Days Hours Min	February 5, 1930	AL	
Usual Residence of Decedent		10a. State			10d. Inside City Limits		
		MD	10b. County		<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
		Cecil		Elkton			
10e. Street and Number		10f. Zip Code			10g. Citizen of What Country?		
217 West Main St.		21921			U.S.A.		
11. Marital Status		12. Was Decedent Ever in U.S. Armed Forces?		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)		14. Race - American Indian, Black, White, etc.	
<input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		Specify: White	
15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)			16b. Kind of Business/Industry		
Elementary/Secondary (0-12) 12		College (1-4 or 5+) 2 Homemaker			Household		
17. Father's Name (First, Middle, Last)		18. Mother's Name (First, Middle, Maiden Surname)					
Charles R. Mintz		Louvenia Weldon					
19a. Informant's Name/Relationship (Type. Print)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)					
Britt-Marie Wrang Orr		296 Smith Rd., Rising Sun, MD 21911					
20a. Method of Disposition		20b. Place of Disposition (Name of cemetery, crematory or other place)		Date	20c. Location - City or Town, State		
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		Arlington National Cemetery		May 8, 2007	Arlington, VA		
21. Signature of Funeral Service Licensee		Name and Address of Facility					
		Andrew G. Gee Funeral Home 259 E. Main St., Elkton, MD 21921					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
Immediate Cause (Final disease or condition resulting in death)							
a. Respiratory arrest Due to (or as a consequence of):							
b. Extensive cancer with metastasis. Due to (or as a consequence of):							
c. Due to (or as a consequence of):							
d. Due to (or as a consequence of):							
Approximate Interval Between Onset and Death							
23b. Was decedent pregnant in the past 12 months?		23c. If yes, outcome pf pregnancy			23d. Date of delivery		
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown		<input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____ <input type="checkbox"/> Unknown			Month	Day	Year
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
Breast cancer							
23e. Did tobacco use contribute to the cause of death?							
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown							
24a. Was an autopsy performed?		24b. Were autopsy findings available prior to completion of cause of death?					
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
25. Was case referred to medical examiner?		26. Place of Death (Check only one)					
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA			Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		
27. Manner of Death		28a. Date of Injury (Month, Day Year)		28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred	
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		<input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		M	<input type="checkbox"/> Yes <input type="checkbox"/> No		
28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one)		29b. Signature and title of certifier					
<input checked="" type="checkbox"/> Medical Examiner		29c. License number					
		29d. Date signed (Month, Day, Year)					
		4/3/2007					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)		29e. Place of residence					
Oden Catayon		223 W Main St. Elkton, MD					
31. Date filed (Month, Day, Year)		32. Registrar's Signature					
APR 4 2007		Gloria A. Spots					

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transit

Medical Certification: To Be Completed by Physician/Medical Examiner

10
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transit

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2007 12313

Reg. No.

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Argyle Thomas Wilson							2. Date of Death Month Day Year March 28, 2007	3. Time of Death 1954 P M
	4a. Facility Name (If not institution, give street and number) 19 Davidson Street			4b. City, Town, or Location of Death Frostburg			4c. County of Death Allegany		
Funeral Director	5. Social Security Number 212-38-6281	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 71 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) 03/23/1936	9. Birthplace (State or Foreign Country) Maryland		
	Usual Residence of Decedent 10a. State MD		10b. County Allegany	10c. City, Town or Location Frostburg			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
To Be Completed by Funeral Director	10e. Street and Number 19 Davidson Street			10f. Zip Code 21532			10g. Citizen of What Country? USA		
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: White			14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Tire Builder			16b. Kind of Business/Industry Tire and Rubber		
	17. Father's Name (First, Middle, Last) Martin Sherman Wilson			18. Mother's Name (First, Middle, Maiden Surname) Hazel Marie Thomas					
	19a. Informant's Name/Relationship (Type, Print) Naomi F. Wilson / wife			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19 Davidson Street, Frostburg, Maryland 21532					
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) ► Robert C. Adams			20b. Place of Disposition (Name of cemetery, crematory or other place) Sunset Memorial Park			Date 04/02/2007	20c. Location - City or Town, State Cumberland, MD	
	21. Signature of Funeral Service Licensee ► Robert C. Adams			22. Name and Address of Facility Adams Family Funeral Home, P.A. 404 Decatur Street, Cumberland, MD 21502					
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Arteriosclerotic Heart Disease Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.								Approximate Interval Between Onset and Death Unknown
	23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year		
Medical Certification: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown
	25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide			28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	28c. Injury at Work? M <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred		
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)		
	29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
	29b. Signature and title of certifier ► Robert C. Adams			29c. License number D09157			29d. Date signed (Month, Day, Year) March 29, 2007		
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Paul Snow, M.D., 124 West Third Street, Cumberland, MD 21502								
State Registrar	31. Date filed (Month, Day, Year) MAR 29 2007		32. Registrar's Signature Robert C. Adams						

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached or used as the burial transit slip.

Permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or if Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2007 12314

Certificate of Death

Reg. No.

1- For State Registrar

Physician / Medical Examiner	1. Decedent's Name (First, Middle, Last) RAYMOND WATSON					2. Date of Death Month 03	Day 30	Year 2007	3. Time of Death 2223 M	
	4a. Facility Name (If not institution, give street and number) WMHS-BRADDOCK CAMPUS			4b. City, Town, or Location of Death CUMBERLAND			4c. County of Death ALLEGANY			
Funeral Director	5. Social Security Number 193-22-8279		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) 77 Yrs.	If Under 1 Year Months 0	If Under 24 Hrs. Days 0	8. Date of Birth (Month, Day, Year) 10/5/1929	9. Birthplace (State or Foreign Country) Pennsylvania		
	Usual Residence of Decedent		10a. State MD	10b. County Allegany	10c. City, Town or Location Cumberland			10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		
To Be Completed by Funeral Director	10e. Street and Number 730 Furnace Street			10f. Zip Code 21502			10g. Citizen of What Country? USA			
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: Black		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Detailer		16b. Kind of Business/Industry Automotive					
	17. Father's Name (First, Middle, Last) Unknown					18. Mother's Name (First, Middle, Maiden Surname) Unknown				
	19a. Informant's Name/Relationship (Type, Print) Harry Merkel / friend			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 550 N. Mechanic Street, Cumberland, MD 21502						
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Cumberland Crematory			Date 04/03/2007	20c. Location - City or Town, State Cumberland, MD			
	21. Signature of Funeral Service Licensee Robert C. Baker		22. Name and Address of Facility Adams Family Funeral Home, P.A. 404 Decatur Street, Cumberland, MD 21502							
Physician / Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) SEPSIS								Approximate Interval Between Onset and Death ONE WEEK	
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last OSTEOMYELITIS, BOTH FEET								ONE WEEK	
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown			23d. Date of delivery Month 04			Year 2007	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year) M		28b. Time of Injury M	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	28d. Describe how injury occurred			
			28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) At home		28f. Location (Street and Number or Rural Route Number, City or Town, State) CUMBERLAND MD 21502					
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29c. License number D-14865			29d. Date signed (Month, Day, Year) MARCH 31st, 2007				
	29b. Signature and title of certifier Robert C. Baker									
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR ROBUSTIANO BARRERA 500 MEMORIAL AVE SUITE 201									
Division or Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	31. Date filed (Month, Day, Year) APR 03 2007		32. Registrar's Signature Robert C. Baker							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 12315

1- For
State
RegistrarPhysician
/Medical
Examiner

		1. Decedent's Name (First, Middle, Last) Rena L. Walker		2. Date of Death Month April Day 2 Year 2007	3. Time of Death 10:47 AM
4a. Facility Name (If not institution, give street and number) Fahrney-Keedy Memorial Home		4b. City, Town, or Location of Death Boonsboro		4c. County of Death Washington	
5. Social Security Number 578-26-7040		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 103 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days Hours Min.
8. Date of Birth (Month, Day, Year) Jan. 10, 1904		9. Birthplace (State or Foreign Country) Wash. DC		10. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10a. State MD		10b. County Frederick	10c. City, Town or Location Middletown		
10e. Street and Number 318 S. Church St.		10f. Zip Code 21769		10g. Citizen of What Country? USA	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) homemaker		16b. Kind of Business/Industry own home	
17. Father's Name (First, Middle, Last) Henry Lavisson		18. Mother's Name (First, Middle, Maiden Surname) Sadie McDuell			
19a. Informant's Name/Relationship (Type, Print) Pamela Taylor (Granddaughter)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 318 S. Church St., Middletown, MD 21769			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) Donald B. Thompson Funeral Home		20b. Place of Disposition (Name of cemetery, crematory or other place) Cedar Hill Cemetery		Date 4/6/07	20c. Location - City or Town, State Suitland, MD
21. Signature of Funeral Service License Thed Schwoapen		22. Name and Address of Facility Donald B. Thompson Funeral Home 31 E. Main St., Middletown, MD 21769		Approximate Interval Between Onset and Death 30 days	
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on this line. Immediate Cause (Final disease or condition resulting in death) Men menia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Hyperension cardiovascular Disease					
a. Due to (or as a consequence of): Men menia		b. Due to (or as a consequence of): Hyperension cardiovascular Disease		c. Due to (or as a consequence of): 	
d. 					
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					
23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA		26. Place of Death (Check only one) Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) 4. Nursing Home	
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29c. License number 052323		29d. Date signed (Month, Day, Year) 04-03-2007	
29b. Signature and title of certifier D. KHALID WASEEM		32. Registrar's Signature Rena L. Walker		31. Date filed (Month, Day, Year) APR 04 2007	
32. Registrar's Signature					

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
 Important: If item 27 is marked other than "natural", or items 23a or 28a show any injury or other traumatic event, the Medical Examiner will be notified at once.

To Be Completed by Funeral Director

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

DHMH 17 Rev 1/2001

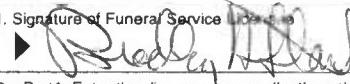
ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2007 12316
Reg. No.

1- For State Registrar		2. Date of Death Month Day Year March 30, 2007								3. Time of Death 7:10 P. M.							
Physician /Medical Examiner		1. Decedent's Name (First, Middle, Last) LOUISE Martha WALTER								4a. Facility Name (if not institution, give street and number) Aspen Woods Senior Living		4b. City, Town, or Location of Death Silver Spring				4c. County of Death Montgomery	
Funeral Director		5. Social Security Number 235-36-1003		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (in yrs. last birthday) 80 Yrs.		If Under 1 Year Months		If Under 24 Hrs. Days		8. Date of Birth (Month, Day, Year) July 29, 1926		9. Birthplace (State or Foreign Country) Thomas, WV			
To Be Completed by Funeral Director		10a. State MD		10b. County Montgomery		10c. City, Town or Location Silver Spring						10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No					
		10e. Street and Number Aspenwood Senior Living Center, #214				10f. Zip Code 20853						10g. Citizen of What Country? USA					
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:						14. Race - American Indian, Black, White, etc. Specify: White							
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+)		16b. Kind of Business/Industry Teacher				17. Father's Name (First, Middle, Last) Joseph ----- Prince				18. Mother's Name (First, Middle, Maiden Surname) Mary ----- Karr					
19a. Informant's Name/Relationship (Type, Print) Christine Colburn/ Daughter		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2137 Elm Tree Lane, Silver Spring, MD 20901		20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Garrett Co. Mem. Gds.		Date 4/2/07		20c. Location - City or Town, State Oakland, Maryland							
21. Signature of Funeral Service 		22. Name and Address of Facility Stewart Funeral Home		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Coronary Artery Disease						Approximate Interval Between Onset and Death Years							
Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		{		a. Due to (or as a consequence of): Coronary Artery Disease													
		b.		Due to (or as a consequence of):													
		c.		Due to (or as a consequence of):													
		d.															
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify)						23d. Date of delivery Month Day Year									
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Rheumatoid Arthritis								23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown									
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) Asst. Living		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year) M		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred					
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) At home, farm, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29c. License number D52261		29d. Date signed (Month, Day, Year) April 1, 2007													
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Alan R. Segal, MD 1517 Hugo Circle, Silver Spring, Maryland 20906		31. Date filed (Month, Day, Year) APR - 8 2007		32. Registrar's Signature 													

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit

Medical Certification: To Be Completed by Physician/Medical Examiner

12
Within 24 hours after death.
completely filled in by the funeral director, page 2 should be detached for use as the burial/transit

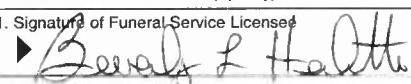
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Amend #10c, 4/3/07, per FHDR, HCHD, a1 Certificate of Death

2007 12317

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Myrtle Koll Wipperfurth					2. Date of Death Month Day Year March 31, 2007	3. Time of Death 5:55 A M
	4a. Facility Name (If not institution, give street and number) Casey House					4b. City, Town, or Location of Death Rockville	4c. County of Death Montgomery
Funeral Director	5. Social Security Number 320-10-7487	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 90 Yrs.	If Under 1 Year Months Days Hours Min. <input type="checkbox"/>	8. Date of Birth (Month, Day, Year) Nov 27, 1916	9. Birthplace (State or Foreign Country) Illinois	
	Usual Residence of Decedent 10a. State MD 10b. County Montgomery					10c. City, Town or Location 403 Russell Avenue #715 Gaithersburg	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
To Be Completed by Funeral Director	10e. Street and Number 403 Russell Avenue #715					10f. Zip Code 20877	10g. Citizen of What Country? USA
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: 1916	13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: White	14. Race - American Indian, Black, White, etc. Specify: White			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+)	16b. Kind of Business/Industry Homemaker				
	17. Father's Name (First, Middle, Last) Henry John Koll	18. Mother's Name (First, Middle, Maiden Surname) Emma Helen Saretsky					
	19a. Informant's Name/Relationship (Type, Print) Susan Joy Leszkiewicz/daughter	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 701 Fallsgrove Drive Rockville, MD 20850 (apt. 309)					
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) Chesapeake Crematory	20b. Place of Disposition (Name of cemetery, crematory or other place) Chesapeake Crematory	Date 04/03/07	20c. Location - City or Town, State Beltsville, MD			
Physician /Medical Examiner	21. Signature of Funeral Service Licensed  Beverly L. Heckrotte	22. Name and Address of Facility Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD 21029					
	23a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Metastatic Melanoma	Approximate Interval Between Onset and Death 10 months					
	23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	23c. If yes, outcome pf pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) Unknown	23d. Date of delivery Month Day Year				
Medical Certification: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) hospice			24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred		
	28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) At home					28f. Location (Street and Number or Rural Route Number, City or Town, State)	
	29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.						
	29b. Signature and title of certifier  Cynthia M. Williams, D.O.	29c. License number H0058032	29d. Date signed (Month, Day, Year) March 31, 2007				
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Cynthia M. Williams, D.O. 6001 Muncaster Mill Rd. Rockville, MD 20855						
State Registrar	31. Date filed (Month, Day, Year) APR 03 2007	32. Registrar's Signature 					

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State of Maryland / Department of Health and Mental Hygiene
2007 12318
Certificate of Death

Reg. No.

1-
For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>Jean McNeilage Wetzel</i>							2. Date of Death Month Day Year <i>APRIL 7 2007</i>	3. Time of Death 09:05 AM		
	4a. Facility Name (If not institution, give street and number) <i>Chester River Hospital C.R.</i>			4b. City, Town, or Location of Death <i>Chestertown</i>			4c. County of Death <i>Kent</i>				
Funeral Director	5. Social Security Number <i>579-42-0012</i>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 90 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days Hours Min.	8. Date of Birth (Month, Day, Year) <i>3/7/1917</i>	9. Birthplace (State or Foreign Country) <i>United Kingdom</i>				
To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State <i>MD</i> 10b. County <i>Kent</i> 10c. City, Town or Location <i>Chestertown</i> 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No										
	10e. Street and Number <i>200 Cannon Street, Apt. 1A</i>			10f. Zip Code <i>21620</i>			10g. Citizen of What Country? <i>United States</i>				
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: <i>4</i>			13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: <i>White</i>			14. Race - American Indian, Black, White, etc. Specify: <i>White</i>			
	15. Decedent's Education (Specify only highest grade completed) <i>Elementary/Secondary (0-12)</i>			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>College (1-4 or 5+)</i> <i>Teacher</i>			16b. Kind of Business/Industry Education				
	17. Father's Name (First, Middle, Last) <i>Albert Christopher Rusack</i>				18. Mother's Name (First, Middle, Maiden Surname) <i>Helen Cruikshank Watson</i>						
	19a. Informant's Name/Relationship (Type, Print) <i>Roger Rusack/Nephew</i>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>2444 Girard Ave S. Minneapolis, MN 55405</i>						
Physician /Medical Examiner	20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <i>Anatomy Gift Registry</i>			20b. Place of Disposition (Name of cemetery, crematory or other place) <i>4/2/2007</i>			Date <i>Hanover, Maryland</i>	20c. Location - City or Town, State			
	21. Signature of Funeral Service Licensee <i>Christine M. Cale</i>				22. Name and Address of Facility <i>Frampton Funeral Home, PA</i> <i>Federalsburg, MD 21632</i>						
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Primary Cause (Final disease or condition resulting in death) <i>Community acquired pneumonia</i> 1 day Secondary list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <i>Rhabdomyolysis</i> 1 day <i>Acute dehydration</i> 1 day										
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown			23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year				
Medical Certification: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Squamous cell carcinoma perianal,</i> <i>Spine stenosis</i> 23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown										
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide			28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred				
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)				
	29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.			29c. License number <i>D51735</i>			29d. Date signed (Month, Day, Year) <i>4/3/07</i>				
	30. Name and title of person who completed cause of death (Item 23a) (Type, Print) <i>Dr. Frederick William Delboy,</i>			31. Date filed (Month, Day, Year) <i>APR 09 2007</i>			32. Registrar's Signature <i>[Signature]</i>				

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 12319

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Warren Harrison Winslow					2. Date of Death Month Day Year March 24 2007	3. Time of Death 2:30 AM	
	4a. Facility Name (If not institution, give street and number) Genesis HealthCare - The Pines			4b. City, Town, or Location of Death Easton		4c. County of Death Talbot		
Funeral Director	5. Social Security Number 242-14-0550	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 89 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Mar. 6, 1918	9. Birthplace (State or Foreign Country) North Carolina	
	Usual Residence of Decedent 10a. State MD			10b. County Talbot			10c. City, Town or Location Easton	
10e. Street and Number 601 Dutchman's Lane			10f. Zip Code 21601			10g. Citizen of What Country? United States		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: 6		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: White			14. Race - American Indian, Black, White, etc. Specify: White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Heavy Equipment Operator		16b. Kind of Business/Industry Equipment Operation				
17. Father's Name (First, Middle, Last) Warren Lasseter Winslow				18. Mother's Name (First, Middle, Maiden Surname) Dorcus Adelia Hilliard Winslow Davis				
19a. Informant's Name/Relationship (Type, Print) Danny J. Brown/ Grandson		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 22395 Hog Creek Road, Preston, MD 21655						
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) Muhah J. Aspin		20b. Place of Disposition (Name of cemetery, crematory or other place) Unity-Washington Cem.		Date 03/26/07	20c. Location - City or Town, State Hurlock, Maryland			
21. Signature of Funeral Service Licensee Muhah J. Aspin		22. Name and Address of Facility Frampton Funeral Home, P.A. 216 N. Main St., Federalsburg, MD 21632						
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Renal Failure							Approximate Interval Between Onset and Death days
	b. infection Due to (or as a consequence of): Advanced dementia							days
c. Advanced dementia							years	
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			23f. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year) M		28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred		
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) At home		28f. Location (Street and Number or Rural Route Number, City or Town, State) EASTON, MD 21601				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29c. License number 325-750			29d. Date signed (Month, Day, Year) 3-26-07			
29b. Signature and title of certifier ROBERT SANCHEZ, MD		32. Registrar's Signature Robert Sanchez						
31. Date filed (Month, Day, Year) MAR 28 2007		32. Registrar's Signature						

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 12320

1- For
State
Registrar

Physician
/Medical
Examiner

Funeral
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036
Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month 3 Day 24 Year 2007		3. Time of Death 1815 ^{PM}
Elizabeth J. Wheatley				
4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of Death Salisbury		4c. County of Death Wicomico
Coastal Hospice at the Lake				
5. Social Security Number 451-50-1604		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 74 Yrs.	8. Date of Birth (Month, Day, Year) Jan. 9, 1933
			If Under 1 Year Months Days Hours Min.	9. Birthplace (State or Foreign Country) New Jersey
Usual Residence of Decedent		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
10a. State MD	10b. County Dorchester	10c. City, Town or Location Cambridge		
10e. Street and Number 5876 Richardson Road		10f. Zip Code 21613		10g. Citizen of What Country? United States
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Insurance Secretary		14. Race - American Indian, Black, White, etc. Specify: White
17. Father's Name (First, Middle, Last) John Eugene Rieben		18. Mother's Name (First, Middle, Maiden Surname) Gladys Jones		
19a. Informant's Name/Relationship (Type, Print) Spouse James D. Wheatley, Sr./		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5876 Richardson Road, Cambridge, MD 21613		
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Stoney Pt. Farm Cem.		Date Apr. 3, 2007
21. Signature of Funeral Service Licensee H. C. Deale CFSP		22. Name and Address of Facility Frampton Funeral Home, P.A. 216 N. Main St., Federalsburg, MD 21632		
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		Approximate Interval Between Onset and Death Lymphoma		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		a. Due to (or as a consequence of):		
		b. Due to (or as a consequence of):		
		c. Due to (or as a consequence of):		
		d. Due to (or as a consequence of):		
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify)		23d. Date of delivery Month Day Year
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Hypertension		23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No
		28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29b. Signature and title of certifier James W. Pearce		29c. License number DIY256		29d. Date signed (Month, Day, Year) 3/25/07
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) COASTAL HOSPICE AT THE LAKE		JAMES W. PEARCE TEERSHEAD HOSPITAL SALISBURY MD 21801		
31. Date filed (Month, Day, Year) MAR 28 2007		32. Registrar's Signature James W. Pearce		

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2007 | 232 |

Reg. No.

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Sadie Glendora Wilt							2. Date of Death Month Day Year April 2, 2007	3. Time of Death 5:34 P M
	4a. Facility Name (If not institution, give street and number) Garrett County Memorial Hospital			4b. City, Town, or Location of Death Oakland			4c. County of Death Garrett		
Funeral Director	5. Social Security Number 218-38-0514	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 93 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days Hours Min.	8. Date of Birth Month Day Year May 5, 1913	9. Birthplace (State or Foreign Country) Maryland		
	Usual Residence of Decedent 10a. State MD		10b. County Garrett		10c. City, Town or Location Mountain Lake Park			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
To Be Completed by Funeral Director	10e. Street and Number 2 W. Second Ave.				10f. Zip Code 21550		10g. Citizen of What Country? USA		
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Housewife			16b. Kind of Business/Industry Home			
	17. Father's Name (First, Middle, Last) Jonas ----- Broadwater				18. Mother's Name (First, Middle, Maiden Surname) Edith Mae Broadwater				
	19a. Informant's Name/Relationship (Type, Print) Jerry L. Wilt/ Son				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15 E. Second Ave., Mountain Lake Park, MD 21550				
Physician /Medical Examiner	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Garrett Co. Mem. Gds.		Date 4/5/07	20c. Location - City or Town, State Oakland, MD			
Medical Certification; To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Stewart Funeral Home		32 S. Second St. Oakland, MD 21550				
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								
	<p>a. Cerebrovascular Accident Due to (or as a consequence of):</p> <p>b. Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. _____</p>								
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown <input type="checkbox"/> Other (specify) _____		23d. Date of delivery Month Day Year				
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. cerebrovascular insufficiency								
	<p>23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown</p> <p>24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>								
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) _____						
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred		
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29c. License number D15333						
	29b. Signature and title of certifier 		29d. Date signed (Month, Day, Year) 4/3/07						
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Thomas Johnson, MD 311 N. Fourth St., Oakland, Maryland 21550								
State Registrar	31. Date filed (Month, Day, Year) APR - 5 2007		32. Registrar's Signature 						

Baltimore, Maryland 21215-0036

Permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28-e show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transit

Division of Vital Records, P.O. Box 68760,

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For Amend #1 Per Phy G866 3/18/07 Jh

Certificate of Death

Reg. No.

2007 12322

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last)		Charlie Frank Adams, JR. J.F. Adams		2. Date of Death		3. Time of Death		
	CHARLIE FRANK				Month APRIL	Day 13	Year 2007	Time 12:40 AM	
Funeral Director	4a. Facility Name (If not institution, give street and number)			4b. City, Town, or Location of Death			4c. County of Death		
	JOHNS HOPKINS HOSPITAL			BALTIMORE CITY					
Usual Residence of Decedent									
10a. State	10b. County	10c. City, Town or Location						10d. Inside City Limits	
MD		BALTIMORE						<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number			10f. Zip Code			10g. Citizen of What Country?			
2601 GROGAN AVE			21213			USA			
11. Marital Status		12. Was Decedent Ever in U.S. Armed Forces?		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)			14. Race - American Indian, Black, White, etc.		
<input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			Specify BLACK		
15. Decedent's Education (Specify only highest grade completed)			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)			16b. Kind of Business/Industry			
Elementary/Secondary (0-12) 11		College (1-4 or 5+) 11		LABORER CONSTRUCTION			PRIVATE CONTRACTOR		
17. Father's Name (First, Middle, Last)				18. Mother's Name (First, Middle, Maiden Surname)					
CHARLIE FRANK ADAMS SR.				CAROLYN WILLIAMS					
19a. Informant's Name/Relationship (Type, Print) mother		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)							
CAROLYN ADAMS		2601 GROGAN AVE 21213 BALTIMORE MD							
20a. Method of Disposition		20b. Place of Disposition (Name of cemetery, crematory or other place)			Date		20c. Location - City or Town, State		
<input checked="" type="checkbox"/> Burial 1 <input type="checkbox"/> Cremation 2 <input type="checkbox"/> Removal from State 3 <input type="checkbox"/> Donation 4 <input type="checkbox"/> Other (Specify)		ST STANISLAUS			4-21-2007		BALTIMORE MD		
21. Signature of Funeral Service Licensee			22. Name and Address of Facility						
Phillip A WEATHERFORD			PHILLIP AWEATHERFORD FLS 2431 E. OLIVER ST						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.									
Immediate Cause (Final disease or condition resulting in death)									
23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									
23c. If yes, outcome of pregnancy									
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 4 <input type="checkbox"/> Pregnant at time of death 9 <input type="checkbox"/> Unknown		3 <input type="checkbox"/> Ectopic pregnancy 5 <input type="checkbox"/> Other (specify) _____		23d. Date of delivery Month Day Year			
23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown									
23f. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No									
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury		28c. Injury at Work? M 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29c. License number RES-000							
29b. Signature and title of certifier LARRY ACTAWEE		29d. Date signed (Month, Day, Year) 4/13/07							
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)		31. Date filed (Month, Day, Year) APR 18 2007							
LARRY ACTAWEE 600 N. Wolfe St. Baltimore, Maryland 21287		32. Registrar's Signature Sue B. Speller							

Baltimore, Maryland 21215-0036

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2007 12323
Reg. No.

1- For
State
Registrar

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

William Paul Aungst

2. Date of Death

Month Day Year

3. Time of Death

April 12, 2007

10:08 AM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

1512 Ridge Rd.

4b. City, Town, or Location of Death

Whiteford

4c. County of Death

Harford

5. Social Security Number

283-28-7829

6. Sex

M

F

7. Age (In yrs. last birthday)

73

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

May 16, 1934

9. Birthplace (State or Foreign Country)

Ohio

Usual Residence of Decedent

10a. State

10b. County

10c. City, Town or Location

10e. Street and Number

1512 Ridge Rd.

10f. Zip Code

21160

10g. Citizen of What Country?

USA

11. Marital Status

Never Married Married
 Widowed Divorced

12. Was Decedent Ever in U.S. Armed Forces?

Yes No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

Yes No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12) College (1-4 or 5+)

4

16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

Senior Physical Scientist

16b. Kind of Business/Industry

Civil Service

17. Father's Name (First, Middle, Last)

Paul L. Aungst

18. Mother's Name (First, Middle, Maiden Surname)

Ollie (unk) Kuhlins

19a. Informant's Name/Relationship (Type, Print)

Erica Aungst/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

10081 Windstream Dr. # 3, Columbia, MD 21044

20a. Method of Disposition

Burial Cremation Removal from State
 Donation Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Date

20c. Location - City or Town, State

Hilltop Service Corp. 4-16-07

Towson, Maryland

21. Signature of Funeral Service Licensee

Erica Aungst

22. Name and Address of Facility

McComas Funeral Home, P.A.

1317 Cokesbury Road, Abingdon, Maryland 21009

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Approximate Interval Between Onset and Death

a. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

Yes No
 Unknown

23c. If yes, outcome of pregnancy

Live birth Fetal death Ectopic pregnancy
 Pregnant at time of death Other (specify)
 Unknown

23d. Date of delivery
Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Diabetes

23e. Did tobacco use contribute to the cause of death?

Yes No Probably Unknown

25. Was case referred to medical examiner?

Yes No

Hospital: 1 Inpatient 2 EP/Outpatient 3 DOA

26. Place of Death (Check only one)

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

27. Manner of Death

1 Natural
2 Accident
3 Suicide
4 Homicide

5 Pending investigation
6 Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

Yes No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Bernard J. Yukna MD, ONE

29c. License number

00014206

29d. Date signed (Month, Day, Year)

April 13, 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BERNARD J. YUKNA, MD, ONE 1614 CHURCHVILLE RD. BEL AIR MD 21015

31. Date filed (Month, Day, Year)

APR 18 2007

32. Registrar's Signature

Laura B. Speller

1

William P. Aungst

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached or used as the burial/transit

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007

12324

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last)				2. Date of Death Month Day Year	3. Time of Death				
	Muriben Vallabhdas Aghera				April 15, 2007		5:40 P M			
Funeral Director	4a. Facility Name (If not institution, give street and number)			4b. City, Town, or Location of Death			4c. County of Death			
	Laurel Regional Hospital			Laurel			Prince George's			
To Be Completed by Funeral Director	5. Social Security Number		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) Yrs. 220-11-3756 75	If Under 1 Year Months Days Hours Min.	8. Date of Birth (Month, Day, Year) May 20, 1931	9. Birthplace (State or Foreign Country) India			
	Usual Residence of Decedent		10a. State Maryland			10b. County Prince George's		10c. City, Town or Location Laurel	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number 14305 Oxford Drive				10f. Zip Code 20707			10g. Citizen of What Country? India			
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 5			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker			16b. Kind of Business/Industry Own Home				
17. Father's Name (First, Middle, Last) Rajabhai Dadhania				18. Mother's Name (First, Middle, Maiden Surname) Kadviben Dedania						
19a. Informant's Name/Relationship (Type, Print) Kirti V. Aghera/son				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14305 Oxford Drive Laurel, Maryland 20707						
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) West Arundel Crematory			Date 4/17/2007	20c. Location - City or Town, State Odenton, Maryland			
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Donaldson Funeral Home & Crematory, P.A. 1411 Annapolis Road Odenton, Maryland 21113						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last									Approximate Interval Between Onset and Death	
<p>a. Acute Pulmonary Edema Due to (or as a consequence of):</p> <p>b. Dilated cardiomyopathy Due to (or as a consequence of):</p> <p>c. Hypertension Due to (or as a consequence of):</p> <p>d.</p>									12 hours	
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown				23c. If yes, outcome pf pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify)					23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. End stage renal disease on chronic hemodialysis for 10 years									23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide				28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred			
				28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29c. License number D047707			29d. Date signed (Month, Day, Year) April 16, 2007			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rita Pabla, M.D. 13621 Baltimore Avenue Laurel, Maryland 20707										
31. Date filed (Month, Day, Year) APR 18 2007				32. Registrar's Signature 						

Baltimore, Maryland 21215-0036

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division or Vital Records, P.O. Box 68760, 
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner


State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 12325

1- For State Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) FREEMAN ALLEN							2. Date of Death Month APRIL Day 16 Year 2007	3. Time of Death M 6:40A M
	4a. Facility Name (If not institution, give street and number) BON SECOURS HOSPITAL			4b. City, Town, or Location of Death BALTIMORE				4c. County of Death N/A	
Funeral Director	5. Social Security Number 216-18-0205	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 83 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month Day Year) Sept. 29, 1923	9. Birthplace (State or Foreign Country) Maryland		
	Usual Residence of Decedent Md. N/A		10c. City, Town or Location Baltimore				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
To Be Completed by Funeral Director	10e. Street and Number 1020 N. McKean Ave.			10f. Zip Code 21217			10g. Citizen of What Country? USA		
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: Black		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 6			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Machinist			16b. Kind of Business/Industry Mary Sue Candy Co.		
	17. Father's Name (First, Middle, Last) James Allen			18. Mother's Name (First, Middle, Maiden Surname) Flossie Dowden					
	19a. Informant's Name/Relationship (Type, Print) Mrs. Rhoda L. Jones			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17 Gondola View Ct. Woodstock, Md. 21163					
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) Garrison Forest			20b. Place of Disposition (Name of cemetery, crematory or other place) 4/24/2007			Date	20c. Location - City or Town, State Owings Mills, Md.	
Physician /Medical Examiner	21. Signature of Funeral Service Licensee Joseph L. Russ			22. Name and Address of Facility Joseph L. Russ Funeral Home, P.A. 2222 W. North Ave., Baltimore, Md. 21216					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) PNEUMONIA						Approximate Interval Between Onset and Death		
	b. Due to (or as a consequence of): HYPERTENSIVE CARDIOVASCULAR DISEASE								
	c. Due to (or as a consequence of): END STAGE RENAL DISEASE								
	d.								
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			23c. If yes, outcome pf pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year		
Medical Certification: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
								24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide			28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred		
				28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)		
	29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
	29b. Signature and title of certifier Rosita R. Cruz M.D.			29c. License number D0030355			29d. Date signed (Month, Day, Year) April 16, 2007		
	30. Name and address of person who completed cause of death (Item 2a) (Type, Print) Rosita R. CRUZ M.D. BON SECOURS HOSPITAL								
State Registrar	31. Date filed (Month, Day, Year) APR 18 2007			32. Registrar's Signature Jean B. Jones					

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified once.

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To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

5

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2007 12326

1- For State Registrar

Physician /Medical Examiner

Funeral Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

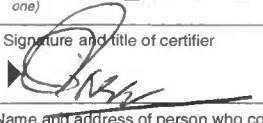
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division or Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State Registrar

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year		3. Time of Death M	
William T. Betz		April 11, 2007		3:51 P M	
4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of Death		4c. County of Death	
9506 Beech Park Street		Capital Heights		Prince George's	
5. Social Security Number	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 68 Yrs.	If Under 1 Year Months Days Hours Min.	8. Date of Birth (Month, Day, Year) Jan 15, 1939	9. Birthplace (State or Foreign Country) Connecticut
042 30 7863					
Usual Residence of Decedent					
10a. State	10b. County	10c. City, Town or Location			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No X
Maryland	Prince George	Capital Heights			
10e. Street and Number 9506 Beech Park Street		10f. Zip Code 20743		10g. Citizen of What Country? United States	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: Vietnam	13. Was Decedent of Hispanic Origin? (Specify Yes or No) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Mechanic			16b. Kind of Business/Industry Air Plane Mechanic
17. Father's Name (First, Middle, Last) James Stenson Betz			18. Mother's Name (First, Middle, Maiden Surname) Beatrice Prevost		
19a. Informant's Name/Relationship (Type, Print) Dehlilah Betz (Daughter)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9506 Beech Park Street, Capital Heights, MD 20743			
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)	20b. Place of Disposition (Name of cemetery, crematory or other place) Lee Crematory		Date	20c. Location - City or Town, State Clinton, Maryland	
21. Signature of Funeral Service Licensee  MO1464		22. Name and Address of Facility Lee Funeral Home, Inc 6633 Old Alexandria Ferry Road, Clinton, MD 20735			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.					
Immediate Cause (Final disease or condition resulting in death) Laryngeal Cancer					
Approximate Interval Between Onset and Death 1 Year					
a. Due to (or as a consequence of):					
b. Due to (or as a consequence of):					
c. Due to (or as a consequence of):					
d. _____					
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome pf pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____ <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Diabetes Mellitus					
23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred
		28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29c. License number D28656			
29b. Signature and title of certifier 		29d. Date signed (Month, Day, Year) April 13, 2007			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ravi Passi, M.D. 15225 Shady Grove Road, #208, Rockville, MD 20850					
31. Date filed (Month, Day, Year) APR 18 2007		32. Registrar's Signature 			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2007 12327

Baltimore, Maryland 21215-0036

Permit: Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the medical examiner must be notified at all times.

Physician /Medical Examiner		1. Decedent's Name (First, Middle, Last) Margaret Marie Brown	2. Date of Death Month April Day 15 Year 2007	3. Time of Death 07:58 AM			
Funeral Director		4a. Facility Name (If not institution, give street and number) The Johns Hopkins Hospital	4b. City, Town, or Location of Death Baltimore City	4c. County of Death N/A			
To Be Completed by Funeral Director		5. Social Security Number 218-32-6478	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 72 Yrs.	If Under 1 Year Months _____ Days _____ Hours _____ Min. _____	8. Date of Birth (Month, Day, Year) 01/17/1935	9. Birthplace (State or Foreign Country) VA
		10a. State MD	10b. County N/A	10c. City, Town or Location Baltimore	10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		
		10e. Street and Number 3634 Raymon Avenue	10f. Zip Code 21213		10g. Citizen of What Country? USA		
		11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: 2000	13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: Black	14. Race - American Indian, Black, White, etc. Specify: Black		
		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th grade	College (1-4 or 5+) N/A	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Nurse	16b. Kind of Business/Industry Health		
		17. Father's Name (First, Middle, Last) George Williams	18. Mother's Name (First, Middle, Maiden Surname) Mary		18. Mother's Name (First, Middle, Maiden Surname) UNK		
		19a. Informant's Name/Relationship (Type, Print) Theresa Brown Sharief/Daughter	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3634 Raymon Avenue Balt. MD 21213				
		20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) ► Briclynn M01363	20b. Place of Disposition (Name of cemetery, crematory or other place) Greenmount Crematory	Date 04/19/07	20c. Location - City or Town, State Baltimore, MD		
		21. Signature of Funeral Service Licensee ► Briclynn M01363	22. Name and Address of Facility Vaughn L. Greene Funeral Services				
		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Gastro Intestinal Hemorrhage	23b. Due to (or as a consequence of): Anemia		Approximate Interval Between Onset and Death 4 Days		
		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	23c. Due to (or as a consequence of): 		4 Days		
		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown	23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 4 <input type="checkbox"/> Pregnant at time of death 9 <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year		
		23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown					
		25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				
		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Homicide 4 <input type="checkbox"/> Homicide	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	28d. Describe how injury occurred	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
		29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
		29b. Signature and title of certifier Elizabeth Lenderman, Medical Doctor	29c. License number Res-000	29d. Date signed (Month, Day, Year) April 17, 2007			
		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Elizabeth Lenderman, The Johns Hopkins Hospital, 600 North Wolfe Street, Baltimore, Maryland 21201					
		31. Date filed (Month, Day, Year) APR 18 2007	32. Registrar's Signature Linda S. Lenderman				

Baltimore, Maryland 21215-0036

permits. Pages 1 and 2 should be filled within 72 hours after death. Department of Health and Mental Hygiene.

Attending Physician: The law requires that the death certificate be executed

To the Hospital or Attorney
within 24 hours after death
To the Funeral Director
completely filled in by the

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 12328

1 - For State Registrar

Physician /Medical Examiner		1. Decedent's Name (First, Middle, Last) Ina Ruth Barker					2. Date of Death Month APRIL Day 13 Year 2007	3. Time of Death 11:50 PM
Funeral Director		4a. Facility Name (If not institution, give street and number) BELAIR HEALTH + RE HAB CENTER		4b. City, Town, or Location of Death BEL AIR			4c. County of Death HARFORD	
To Be Completed by Funeral Director		5. Social Security Number 215-40-0307	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (in yrs. last birthday) 90 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) July 16, 1916	9. Birthplace (State or Foreign Country) North Carolina
		Usual Residence of Decedent 10a. State Maryland		10b. County Harford			10c. City, Town or Location Bel Air	
		10e. Street and Number 2002 White House Road		10f. Zip Code 21015			10g. Citizen of What Country? USA	
		11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: White			14. Race - American Indian, Black, White, etc. Specify: White
		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker			16b. Kind of Business/Industry Own Home	
		17. Father's Name (First, Middle, Last) Arthur David Testerman		18. Mother's Name (First, Middle, Maiden Surname) Margaret (nmn) Heath				
		19a. Informant's Name/Relationship (Type, Print) Karen L. Fouse / Daughter		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2006 White House Road, Bel Air, MD 21015				
		20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) Baptist View Church Cem. 4-17-07		20b. Place of Disposition (Name of cemetery, crematory or other place)		Date	20c. Location - City or Town, State Forest Hill, MD	
		21. Signature of Funeral Service Licensee Charles Amy		22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009				
		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		23b. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last			Approximate Interval Between Onset and Death	
		a. Arteriosclerotic cardiovascular disease Due to (or as a consequence of):		b. Respiratory Failure Due to (or as a consequence of):				
		c. Chronic obstructive pulmonary disease Due to (or as a consequence of):		d. Arthritis				
		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year	
		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
		25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
		27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred
		29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
		29b. Signature and title of certifier J. T. Lee MD		29c. License number D20661		29d. Date signed (Month, Day, Year) 4/14/07		
		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) J. T. Lee MD 669 Revolution St. Haine de Grace MD 21078		31. Date filed (Month, Day, Year) APR 18 2007		32. Registrar's Signature James B. Gandy		

Baltimore, Maryland 21215-0036

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

R. BARKER
Division or Vital Records, P.O. Box 68760, 85

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

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State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007

12329

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Gennady I. Belchansky					2. Date of Death Month April Day 16, Year 2007	3. Time of Death 4:18 P M	
	4a. Facility Name (If not institution, give street and number) Gilchrist Center			4b. City, Town, or Location of Death Towson		4c. County of Death Baltimore		
Funeral Director	5. Social Security Number 574-35-6033	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 70 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days Hours Min.	8. Date of Birth (Month, Day, Year) November 10, 1936	9. Birthplace (State or Foreign Country) Ukraine	
	Usual Residence of Decedent Russia			10c. City, Town or Location MOSCOW			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
To Be Completed by Funeral Director	10e. Street and Number 12-2 B Afanasevsky Street			10f. Zip Code 119109		10g. Citizen of What Country? Russia		
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: 5+		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: White			14. Race - American Indian, Black, White, etc. Specify:	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Professor		16b. Kind of Business/Industry Science			
	17. Father's Name (First, Middle, Last) Illia Belchansky			18. Mother's Name (First, Middle, Maiden Surname) Alexandra Zolotova				
	19a. Informant's Name/Relationship (Type, Print) Tatiana Belchansky/Wife			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12-2 B Afanasevsky Street, Moscow, Russia 119109				
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) Holy Trinity Cemetery		20b. Place of Disposition (Name of cemetery, crematory or other place) Elkridge, Maryland		Date 4/20/07	20c. Location - City or Town, State Elkridge, Maryland		
Physician /Medical Examiner	21. Signature of Funeral Service Licensee Michael P. Marzullo		22. Name and Address of Facility Marzullo Funeral Chapel, P.A. 6009 Harford Road Baltimore, Maryland					
To Be Completed by Physician/Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Prostate Cancer Approximate Interval Between Onset and Death years							
	23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown							
	23c. If yes, outcome pf pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____ <input type="checkbox"/> Unknown							
	23d. Date of delivery Month Day Year							
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
	23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown							
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No			
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	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred	
	28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)							
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
	29b. Signature and title of certifier Almanus				29c. License number 058303		29d. Date signed (Month, Day, Year) April 17 2007	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) John J. Clark 6701 N. Charles St. Baltimore 21203							
	31. Date filed (Month, Day, Year) APR 18 2007		32. Registrar's Signature Anna L. Apelle					

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division or Vital Records, P.O. Box 68760, *Ey*

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Amend #5, per FH, 0368, 6/4/07 IT
Registrar

Certificate of Death

Reg. No.

2007 12330

Physician
/Medical
Examiner

Funeral
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
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Division or Vital Records, P.O. Box 68760,

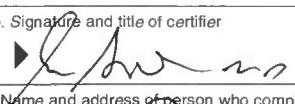
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Physician
/Medical
Examiner

Funeral
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Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0036
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month Day Year			3. Time of Death		
Frieda M. Ball			April 11, 2007			5:00 A M		
4a. Facility Name (If not institution, give street and number)			4b. City, Town, or Location of Death			4c. County of Death		
Montgomery General Hospital			Olney			Montgomery		
5. Social Security Number 295-12-6600 295-14-0736	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 83 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	Hours	8. Date of Birth (Month, Day, Year) May 14, 1923	9. Birthplace (State or Foreign Country) Ohio	
Usual Residence of Decedent								
10a. State Maryland	10b. County Montgomery	10c. City, Town or Location Silver Spring					10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number 14801 Pennfield Circle, #105			10f. Zip Code 20906			10g. Citizen of What Country? United States		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 4		16b. Kind of Business/Industry Homemaker			Own Home	
17. Father's Name (First, Middle, Last) Leo White				18. Mother's Name (First, Middle, Maiden Surname) Freda Fitzer				
19a. Informant's Name/Relationship (Type, Print) Tamara B. Vollmer/Daughter			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14701 Westbury Road, Rockville, Maryland 20853					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Arlington National			Date May 17, 2007	20c. Location - City or Town, State Arlington, Virginia		
21. Signature of Funeral Service Licensee  M01173			22. Name and Address of Facility Robert A. Pumphrey Funeral Home, Rockville, Inc. 300 W. Montgomery Avenue, Rockville, Maryland 20850					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.								
Immediate Cause (Final disease or condition resulting in death)								
a. <i>Lower Gastrointestinal Bleeding</i> Due to (or as a consequence of): Approximate Interval Between Onset and Death 8 Days								
b. _____ Due to (or as a consequence of):								
c. _____ Due to (or as a consequence of):								
d. _____								
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown <input type="checkbox"/> Other (Specify) _____					23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Deep Vein Thrombophlebitis</i> <i>Cerebrovascular Accident</i> <i>Hypertension, Coronary bypass Surgery</i>								
23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown								
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred		
		28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier 				29c. License number D18726			29d. Date signed (Month, Day, Year) Apr. 11, 2007	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ARTHUR SCHAEENGOLD, MD 18101 Prince Philip Dr., OLNEY, MD 20832								
31. Date filed (Month, Day, Year) APR 18 2007		32. Registrar's Signature 						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

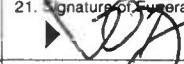
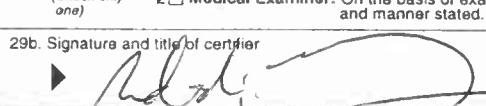
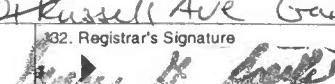
State of Maryland / Department of Health and Mental Hygiene

2007 12331

Certificate of Death

Reg. No.

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Susie E Byrne							2. Date of Death Month Apr. Day 16 Year 2007	3. Time of Death 10 30 A M
	4a. Facility Name (If not institution, give street and number) Wilson Healthcare Center			4b. City, Town, or Location of Death Gaithersburg			4c. County of Death Montgomery		
Funeral Director	5. Social Security Number 219-16-3836	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 102 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days Hours Min.	8. Date of Birth (Month, Day, Year) 9/23/1904	9. Birthplace (State or Foreign Country) MARYLAND		
Usual Residence of Decedent 10a. State MD 10b. County CITY 10c. City, Town or Location BALTIMORE 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No									
10e. Street and Number 2813 GREENLAWN RD.					10f. Zip Code 21207			10g. Citizen of What Country? USA	
Physician /Medical Examiner	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: WHITE	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10					16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) HOUSEWIFE			16b. Kind of Business/Industry HOME MAKER	
17. Father's Name (First, Middle, Last) HARVEY C. LOATS					18. Mother's Name (First, Middle, Maiden Surname) LINA BURRIER				
19a. Informant's Name/Relationship (Type, Print) WILLIAM C. BYRNE -SON					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2813 GREENLAWN RD., BALTIMORE, MD 21207				
Physician /Medical Examiner	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)	20b. Place of Disposition (Name of cemetery, crematory or other place) DRUID RIDGE CEM.			Date 4/18/07	20c. Location - City or Town, State PIKESVILLE, MD			
21. Signature of Funeral Service Licensee 					22. Name and Address of Facility FLETCHER FUNERAL HOME, P.A. 254 E. MAIN ST., WESTMINSTER, MD 21157				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Coronary Artery Disease									
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last									
23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown									
23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____ <input type="checkbox"/> Unknown									
23d. Date of delivery Month Day Year									
23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown									
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
27. Manner of death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide					28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 28c. Injury at Work? 28d. Describe how injury occurred				
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)									
28f. Location (Street and Number or Rural Route Number, City or Town, State)									
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
29b. Signature and title of certifier 									
29c. License number DO059423									
29d. Date signed (Month, Day, Year) April 17 2007									
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Michael Feinberg 201 Russell Ave Gaithersburg MD 20877									
31. Date filed (Month, Day, Year) APR 18 2007									
32. Registrar's Signature 									

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or items 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene
Amend #7, per FH, C866, 4/18/07 TT
1- For State Registrar Certificate of Death Reg. No. 2007 12332

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) ANNA BEHRMAN						2. Date of Death Month April Day 15 Year 2007	3. Time of Death 10:10 PM
	4a. Facility Name (If not institution, give street and number) SINAI HOSPITAL OF BALTIMORE			4b. City, Town, or Location of Death BALTIMORE CITY			4c. County of Death N/A	
Funeral Director	5. Social Security Number 220-15-7335	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 81 - 82 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Hours	8. Date of Birth (Month, Day, Year) 12/22/1925	9. Birthplace (State or Foreign Country) MD	
	Usual Residence of Decedent 10a. State MD 10b. County BALTIMORE 10c. City, Town or Location BALTIMORE			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
To Be Completed by Funeral Director	10e. Street and Number 8100 ARROWHEAD ROAD			10f. Zip Code 21208			10g. Citizen of What Country? U.S.A.	
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married X <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: X		13. Was Decedent of Hispanic Origin? (Specify Yes or No) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: WHITE	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 2 College (1-4 or 5+) 2			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) HOMEMAKER			16b. Kind of Business/Industry OWN HOME	
	17. Father's Name (First, Middle, Last) ISADORE HYMOWITZ			18. Mother's Name (First, Middle, Maiden Surname) MARY FRIEDLANDER				
	19a. Informant's Name/Relationship (Type, Print) LEON BEHRMAN / HUSBAND			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8100 ARROWHEAD ROAD - BALTIMORE, MD 21208				
Physician /Medical Examiner	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) HAR Tzion TIFERETH ISRAEL CONG.			Date 04/16/2007 20c. Location - City or Town, State ROSEDALE, MD	
	21. Signature of Funeral Service Licensee 			22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208				
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							
	<p>a. Due to (or as a consequence of): Ursepsis</p> <p>b. Due to (or as a consequence of): ACUTE myocardial infarction</p> <p>c. Due to (or as a consequence of):</p> <p>d. _____</p>							
	Approximate Interval Between Onset and Death							
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown			23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Cerebrovascular accident							
	23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown							
	<p>24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p>							
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
	<p>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)</p>							
	26. Place of Death (Check only one)							
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide							
	<p>28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>							
	28d. Describe how injury occurred							
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)							
	28f. Location (Street and Number or Rural Route Number, City or Town, State)							
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
	29b. Signature and title of certifier 							
	29c. License number RES-000							
	29d. Date signed (Month, Day, Year) April 15, 2007							
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KATJA KISELJAK VASSILIADES, DO SINAI HOSPITAL OF BALTIMORE							
	31. Date filed (Month, Day, Year) APR 18 2007		32. Registrar's Signature 					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Amend #11,19b, per FH, g866, 4/18/07 T Certificate of Death

Reg. No. 2007 12333

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) THERESA BRAUNSTEIN				2. Date of Death Month April Day 12 Year 2007	3. Time of Death 5:50 P M		
	4a. Facility Name (If not institution, give street and number) HOSPICE OF BALTIMORE GILCHRIST CTR.		4b. City, Town, or Location of Death TOWSON		4c. County of Death BALTIMORE			
Funeral Director	5. Social Security Number 138-07-9102	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 95 Yrs.	If Under 1 Year Months Days Hours Min.	8. Date of Birth (Month, Day, Year) 02/12/1912	9. Birthplace (State or Foreign Country) NJ		
	Usual Residence of Decedent 10a. State MD 10b. County N/A 10c. City, Town or Location BALTIMORE				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
To Be Completed by Funeral Director	10e. Street and Number 3601 FORDS LANE #205			10f. Zip Code 21215	10g. Citizen of What Country? U.S.A.			
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: 2001		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: White		14. Race - American Indian, Black, White, etc. Specify: White		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) BANK TELLER		16b. Kind of Business/Industry FINANCIAL			
	17. Father's Name (First, Middle, Last) PHILLIP WEININGER			18. Mother's Name (First, Middle, Maiden Surname) EVELYN ROTHMAN				
	19a. Informant's Name/Relationship (Type, Print) MARYLYN KOPELSON/DAUGHTER			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 22 PICKERSGILL SQUARE - OWINGS MILLS, MD 21117				
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input checked="" type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) MT. MORIAH			Date 04/16/2007	20c. Location - City or Town, State FAIRVIEW, NJ			
	21. Signature of Funeral Service Licensee <i>Michael Bruger</i>			22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208				
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <i>Am 10 trophic lateral sclerosis</i> Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. _____						Approximate Interval Between Onset and Death months	
	23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown			23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) Unknown			23d. Date of delivery Month Day Year	
Medical Certification: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) Hospital				
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred	
	28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State)	
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.			29c. License number D25205			29d. Date signed (Month, Day, Year) April 13, 2007	
	29b. Signature and title of certifier <i>W.A.Riley</i>			31. Date filed (Month, Day, Year) APR 18 2007			32. Registrar's Signature <i>Debra B. Lester</i>	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 12334

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Pearl Ann Craig							2. Date of Death Month Day Year April 15, 2007	3. Time of Death 5:00 AM	
	4a. Facility Name (If not institution, give street and number) Bradford Oaks Nursing Home				4b. City, Town, or Location of Death Clinton			4c. County of Death Prince George's		
Funeral Director	5. Social Security Number 301-22-7539		6. Sex 1 M 2 F X	7. Age (In yrs. last birthday) 76 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) Jan 22, 1931	9. Birthplace (State or Foreign Country) Ohio		
Usual Residence of Decedent 10a. State MD 10b. County Prince George's 10c. City, Town or Location Clinton 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No X										
10e. Street and Number 9517 Juliette Drive				10f. Zip Code 20735			10g. Citizen of What Country? USA			
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: (Unk)			13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: X			14. Race - American Indian, Black, White, etc. Specify: Black	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 4				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Nursing			16b. Kind of Business/Industry Medical			
17. Father's Name (First, Middle, Last) Glenn Turner					18. Mother's Name (First, Middle, Maiden Surname) Maxine Walker					
19a. Informant's Name/Relationship (Type, Print) Candace J. Craig - Daughter					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9517 Juliette Drive Clinton, MD 20735					
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) Funeral Underwriter			20b. Place of Disposition (Name of cemetery, crematory or other place) MD National Mem. Park			Date 4/20/07	20c. Location - City or Town, State Laurel, MD			
21. Signature of Funeral Service Licensee Jean Blendle			22. Name and Address of Facility A.L. Bennett Funeral Home 515 Princess Anne St. Fredericksburg, VA							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Final Underlying Cause (Disease or injury that initiated events resulting in death) Last										Approximate Interval Between Onset and Death
<p>a. Parkinson's Disease Due to (or as a consequence of):</p> <p>b. _____ Due to (or as a consequence of):</p> <p>c. _____ Due to (or as a consequence of):</p> <p>d. _____</p>										
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown			23c. If yes, outcome pf pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) Unknown			23d. Date of delivery Month Day Year				
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide			28a. Date of Injury (Month, Day Year) M 28b. Time of Injury M 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			28d. Describe how injury occurred				
28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) At home						28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
29b. Signature and title of certifier William T. Tanner			29c. License number D35206			29d. Date signed (Month, Day, Year) April 16, 2007				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) William Tanner, MD 11701 Livingston Road Ft. Washington, MD 20744										
31. Date filed (Month, Day, Year) APR 18 2007			32. Registrar's Signature Leanne L. Parker							

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2007 12335

1- For State Registrar**Physician/
Medical Examiner**

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death 2021 hrs
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Helen M. Chalmers

April 13, 2007

2021 hrs

Funeral Director

4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
--	--------------------------------------	---------------------

Johns Hopkins Bayview Medical Center

Baltimore

N/A

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth (MM/DD/YYYY)	9. Birthplace (State or Foreign Country)
213-62-3861	1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	54 Yrs.	Months	Days	Hours	Maryland

March 12, 1953

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
------------	-------------	-----------------------------	--

Maryland Baltimore

Edgemere

10d. Inside City Limits

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
------------------------	---------------	-------------------------------

9036 Hinton Avenue

21219

United States

11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No specify: Specify White	14. Race - American Indian, Black, White, etc.
--	---	---	--

15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+)	16b. Kind of Business/Industry Homemaker
--	--	---

+1

Own Home

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
---	---

Robert Jackson

Elizabeth Dillon

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
--	---

Karl A. Chalmers, Jr. (Husband) 9036 Hinton Avenue Edgemere, Maryland 21219

20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
---	--	------	-------------------------------------

4 Donation 5 Other Specify Hilltop Service Corp. 4/17/2007 Towson, Maryland

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
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Hilltop Service Corp. 7922 Wise Avenue Dundalk, Inc. Dundalk, Maryland 21222

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.	Approximate Interval Between Onset and Death
---	--

Immediate Cause (Final disease or condition resulting in death)

a. Asphyxia by hanging

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

 UNPENDED AMENDED

IF FEMALE:	23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown	23d. Date of delivery Month Day Year
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23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input checked="" type="checkbox"/> Unknown	23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown
---	--

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23f. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> N 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
--	--

25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other:
---	---

27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input checked="" type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide	28a. Date of Injury (Month, Day, Year) FOUND: Apr 13, 2007	28b. Time of Injury FOUND: 1930 hrs	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	28d. Describe how injury occurred Subject hanged self
--	---	--	---	--

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Single Family	28f. Location (Street and Number or Rural Route Number, City or Town, State) 9036 Hinton Ave, Dundalk, MD
---	--

29a. Certifier 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.	29b. Signature and title of certifier <i>Zabiullah Ali, M.D.</i>	29c. License number O.C.M.E.	29d. Date signed (Month, Day, Year) April 14, 2007
---	---	---------------------------------	---

30. Name and address of person who completed cause of death (Item 23a) Zabiullah Ali, M.D. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

31. Date filed (Month, Day, Year) APR 18 2007	32. Registrar's Signature <i>Helen K. Foster</i>
--	---

Baltimore, MD 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician, page 2 should be detached for use as the burial - transit

Within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician, page 2 should be detached for use as the burial - transit

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

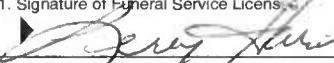
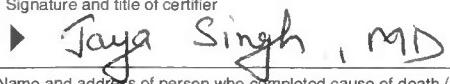
amend item 5 per th g867 5-7-07 vt

State of Maryland / Department of Health and Mental Hygiene

1- For State Amend #10e, per FH, G866, 4/18/07 TT Certificate of Death

Reg. No.

2007 12336

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Kenneth Allen Connor				2. Date of Death Month Day Year APRIL 15 2007 06:47 AM	3. Time of Death	
	4a. Facility Name (If not institution, give street and number) Union Memorial Hospital		4b. City, Town, or Location of Death Baltimore		4c. County of Death N/A		
Funeral Director	5. Security Number 216-64-5358	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 48 Yrs.	If Under 1 Year Months Days Hours Min. 0 0 0 0	If Under 24 Hrs. Hours Min. 0 0	8. Date of Birth (Month, Day, Year) Oct. 25, 1958	9. Birthplace (State or Foreign Country) Maryland
	10a. State Maryland		10b. County N/A	10c. City, Town or Location Baltimore			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No XX
To Be Completed by Funeral Director	10e. Street and Number 512 5102 Cordelia Ave.			10f. Zip Code 21215		10g. Citizen of What Country? USA	
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: 1958		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: Black		14. Race - American Indian, Black, White, etc.
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Laborer		16b. Kind of Business/Industry Pennsylvania Railroad		
	17. Father's Name (First, Middle, Last) Joseph Connor			18. Mother's Name (First, Middle, Maiden Surname) Justine white			
	19a. Informant's Name/Relationship (Type, Print) Justine Connor/ Mother			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5102 Cordelia Avenue Baltimore, Md 21215			
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) Bayview Crematory		20b. Place of Disposition (Name of cemetery, crematory or other place) Bayview Crematory		Date 4/18/07	20c. Location - City or Town, State Dundalk, Maryland	
	21. Signature of Funeral Service License 			22. Name and Address of Facility Chatman-Harris Funeral Home 5240 Reisterstown Rd Baltimore, Md 21215			
Physician /Medical Examiner	<p>23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.</p> <p>Immediate Cause (Final disease or condition resulting in death) SEPTIC SHOCK Due to (or as a consequence of): HYPERNATREMIA Due to (or as a consequence of): RENAL FAILURE Due to (or as a consequence of):</p> <p>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</p> <p>Approximate Interval Between Onset and Death 1 DAY</p> <p>1 DAY</p> <p>1 DAY</p> <p>{</p>						
Medical Certification: To Be Completed by Physician/Medical Examiner	<p>IF FEMALE:</p> <p>23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown</p> <p>23c. If yes, outcome pf pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown</p> <p>23d. Date of delivery Month Day Year</p> <p>Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ACQUIRED IMMUNODEFICIENCY SYNDROME</p> <p>23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown</p> <p>24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p>						
	<p>25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)</p> <p>26. Place of Death (Check only one)</p>						
	<p>27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide</p> <p>28a. Date of Injury (Month, Day, Year) 28b. Time of Injury M 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>28d. Describe how injury occurred</p> <p>28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)</p> <p>28f. Location (Street and Number or Rural Route Number, City or Town, State)</p>						
	<p>29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.</p> <p>29b. Signature and title of certifier </p> <p>29c. License number AT2438946</p> <p>29d. Date signed (Month, Day, Year) APRIL 15 2007</p>						
	<p>30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JAYA SINGH, MD, 204 EAST UNIVERSITY PARKWAY, BALTIMORE, MD 21218</p> <p>31. Date filed (Month, Day, Year) APR 18 2007</p> <p>32. Registrar's Signature </p>						

Baltimore, Maryland 21215-0036

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division or Vital Records, P.O. Box 68760, 

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 12337

1- For
State
Registrar

Physician
/Medical
Examiner

Funeral
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 2a or 2a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21268-0760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year		3. Time of Death
Harry Willis Copeland		April 14, 2007		9:10 AM
4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of Death		4c. County of Death
Madonna Heritage Assisted Living		Jarrettsville		Harford
5. Social Security Number		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 86 Yrs.	If Under 1 Year Months Days Hours Min. If Under 24 Hrs.
251-22-0414				
10a. State		10b. County	10c. City, Town or Location	
Maryland		Harford	Bel Air	
10e. Street and Number		10f. Zip Code		10g. Citizen of What Country?
507 Hanna Road		21014		USA
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: 14. Race - American Indian, Black, White, etc. Specify: White
Elementary/Secondary (0-12)		College (1-4 or 5+) 2		15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry
17. Father's Name (First, Middle, Last)		18. Mother's Name (First, Middle, Maiden Surname)		Mae (nmn) Bryan
Harry Lee Copeland		19a. Informant's Name/Relationship (Type, Print)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Vivian Copeland / Daughter				507 Hanna Road, Bel Air, MD 21014
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place)		Date 20c. Location - City or Town, State
		Holly Hill Memorial Grdn 4-18-07		Baltimore, Maryland
21. Signature of Funeral Service Licensee <i>Charles J. Engle</i>		22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009		
23a. Part 1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.		23b. Enter the underlying cause (Disease or injury that initiated events resulting in death) Last		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)		a. Due to (or as a consequence of): <i>Vascular dementia</i>		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		b. Due to (or as a consequence of):		
{		c. Due to (or as a consequence of):		
d. Due to (or as a consequence of):				
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year
24. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		
<i>Diabetes</i> <i>recent nose surgery</i> <i>Hypertension</i>				
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M
		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				
29b. Signature and title of certifier <i>David S. Dunn</i>		29c. License number <i>DB2255</i>		29d. Date signed (Month, Day, Year) <i>April 16, 2007</i>
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)				
<i>David S. Dunn 6-5 W. Main St., Bel Air, MD</i>				
31. Date filed (Month, Day, Year) <i>APR 18 2007</i>		32. Registrar's Signature <i>Susan B. Speller</i>		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amend #7 Per FM Good 4/18/07 JH

Certificate of Death

Reg. No.

2007 12338

1- For State Registrar

Physician/
Medical ExaminerFuneral
Director

To Be Completed by Funeral Director

Baltimore, MD 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician/ Medical Examiner		1. Decedent's Name (First, Middle, Last) Cuyjet Clark				2. Date of Death Month Day Year April 14, 2007		3. Time of Death 0133 hrs					
Funeral Director		4a. Facility Name (if not institution, give street and number) St. Agnes Hospital				4b. City, Town, or Location of Death Baltimore		4c. County of Death					
		5. Social Security Number 217-80-4086	6. Sex M	7. Age (In yrs. last birthday) 45	8. If Under 1 Year Months 62	9. If Under 24 Hrs. Days	10. Date of Birth (MM/DD/YYYY) 01/18/1962	11. Birthplace (State or Foreign Country) MD					
		12. Was Decedent Ever in U.S. Armed Forces? X Yes 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:				13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: African American							
		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) domestic				16b. Kind of Business/Industry homemaker					
		17. Father's Name (First, Middle, Last) Donald Clark, Sr.				18. Mother's Name (First, Middle, Maiden Surname) Dorothy Goodrich							
		19a. Informant's Name/Relationship (Type, Print) Nicole Robinson / Daughter		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 516 Chester Street; Baltimore, Maryland 21201									
		20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other Specify: Jesuela Jones		20b. Place of Disposition (Name of cemetery, crematory or other place) Trinity Cemetery		Date 04/21/2007		20c. Location - City or Town, State Baltimore, Maryland					
		21. Signature of Funeral Service Licensee Jesuela Jones		22. Name and Address of Facility Wylie Funeral Home, P.A. 638 North Gilmor Street; Baltimore, Maryland 21217									
Physician/ Medical Examiner		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.								Approximate Interval Between Onset and Death			
		a. Pneumonia Due to (or as a consequence of):											
		b. _____ Due to (or as a consequence of):											
		c. _____ Due to (or as a consequence of):											
		d. _____											
		<input type="checkbox"/> UNPENDED		<input type="checkbox"/> AMENDED									
		IF FEMALE:		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown								23d. Date of delivery Month Day Year	
		23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input checked="" type="checkbox"/> Unknown											
		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Cirrhosis of liver								23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
		25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other:									
		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury		28c. Injury at Work?		28d. Describe how injury occurred 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)									
		29a. Certifier 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.											
		29b. Signature and title of certifier Margarita Korell MD		29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) April 14, 2007							
		30. Name and address of person who completed cause of death (Item 23a) Margarita Korell MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201											
State Registrar		31. Date filed (Month, Day, Year) APR 18 2007		32. Registrar's Signature Jesuela Jones									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2007 12339

1- For State Registrar**Physician/Medical Examiner**

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death 1927 hrs
Jack Cole, Jr.	April 14, 2007	

Funeral Director

4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Harbor Hospital	Baltimore	

5. Social Security Number	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 55 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (MM/DD/YYYY) 2-27-1952	9. Birthplace (State or Foreign Country) MD
216-54-6071						

10a. State MD	10b. County n/a	10c. City, Town or Location Baltimore	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
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10e. Street and Number 1620 Cereal Street	10f. Zip Code 21225	10g. Citizen of What Country? United States
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11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No specify:	14. Race - American Indian, Black, White, etc. White
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	If Yes, Give Year or Dates:		Specify

15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10 years	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) n/a	16b. Kind of Business/Industry Carpenter
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17. Father's Name (First, Middle, Last) Jack Cole, Sr.	18. Mother's Name (First, Middle, Maiden Surname) Geraldine Ferguson
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19a. Informant's Name/Relationship (Type, Print) Gary Cole (brother)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4100 Doris Ave. Baltimore, MD 21225
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20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State	20b. Place of Disposition (Name of cemetery, crematory or other place) Bayview Crematory	Date 4-17-2007	20c. Location - City or Town, State Baltimore, MD
<input type="checkbox"/> Donation <input type="checkbox"/> Other Specify:			

21. Signature of Funeral Service Licensee 	22. Name and Address of Facility McCully-Polyuniak Funeral Home, P.A. 237 E. Patapsco Ave. Baltimore, MD 21225
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23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)	a. <u>Atherosclerotic cardiovascular disease</u> Due to (or as a consequence of):	Approximate Interval Between Onset and Death
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Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):	
	c. Due to (or as a consequence of):	
	d. Due to (or as a consequence of):	

<input checked="" type="checkbox"/> UNPENDED <input type="checkbox"/> AMENDED	#23a, PII, 27, per ME, g867, 5/15/07 TT	
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IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Unknown	23d. Date of delivery Month Day Year
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Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown
<u>Chronic alcoholism</u>	

24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
---	--

25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	26 Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other:
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27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier 	29c. License number O.C.M.E.	29d. Date signed (Month, Day, Year) April 15, 2007
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30. Name and address of person who completed cause of death (Item 23a) Theodore M. King, Jr., MD. Assistant Medical Examiner	111 Penn Street, Baltimore, MD 21201
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31. Date filed (Month, Day, Year) APR 18 2007	32. Registrar's Signature
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Baltimore, MD 21215-0036

permit Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transit slip.

Division of Vital Records, P.O. Box 68760,
To the Hospital or Attending Physician: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transit slip.

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2007 12340

1. For State
RegistrarPhysician/
Medical ExaminerFuneral
Director

To Be Completed by Funeral Director

Baltimore, MD 21215-0036

Permit - Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a show any
injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,
To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial - transit

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year		3. Time of Death 0035 hrs
Tavon Campbell		April 11, 2007		
4a. Facility Name (If not institution, give street and number) Johns Hopkins Hospital		4b. City, Town, or Location of Death Baltimore		4c. County of Death N/A
5. Social Security Number 219-21-9316		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 20 Yrs.	8. Date of Birth (MM/DD/YYYY) February 17/1987
			If Under 1 Year Months Days Hours Min.	9. Birthplace (State or Foreign Country) m.d.
10a. State MD		10b. County N/A	10c. City, Town or Location Baltimore	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes		<input type="checkbox"/> No		
10e. Street and Number 1104 Orleans ST		10f. Zip Code 21202		10g. Citizen of What Country? U.S.A.
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: BLACK	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11 GRADE		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) None		16b. Kind of Business/Industry None
17. Father's Name (First, Middle, Last) BERNARD CAMPBELL		18. Mother's Name (First, Middle, Maiden Surname) DINA FUBANKS		
19a. Informant's Name/Relationship (Type, Print) CAROLYN LILLY		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2416 MC ELDALE ST. BALTIMORE MD 21205		
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other Specify:		20b. Place of Disposition (Name of cemetery, crematory or other place) MT ZION CEMETERY		Date Apr. 11/2007
20c. Location - City or Town, State BALTIMORE, MD				
21. Signature of Funeral Service Licensee Patricia Bitt		22. Name and Address of Facility BETTS FUNERAL HOME 1104 Orleans ST. BALTIMORE MD 21203		
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.				
a. Multiple Gunshot Wounds Due to (or as a consequence of):				
b. _____ Due to (or as a consequence of):				
c. _____ Due to (or as a consequence of):				
d. _____				
<input type="checkbox"/> UNPENDED		<input type="checkbox"/> AMENDED		
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown		
23d. Date of delivery Month Day Year				
23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown				
24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No				
26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other:				
27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input checked="" type="checkbox"/> Homicide		28a. Date of Injury (Month Day Year) Apr 11, 2007		
		28b. Time of Injury 0023 hrs	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred Subject shot
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Local Street		28f. Location (Street and Number or Rural Route Number, City or Town, State) 2800 Block East Madison Street, Baltimore, MD		
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				
29b. Signature and title of certifier Susan Hogan MD. Assistant Medical Examiner		29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) April 11, 2007
31. Date filed (Month, Day, Year) APR 18 2007				
32. Registrar's Signature Leanne H. Jones				

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2007 12341

1- For State Registrar

Physician /Medical Examiner

Funeral Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

		1. Decedent's Name (First, Middle, Last)				2. Date of Death Month Day Year		3. Time of Death	
		Andre Delaney				April 12 2007		6:40 P.M.	
4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of Death				4c. County of Death			
Northwest Hospital Center		Randallstown				Balto.			
5. Social Security Number		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday)	If Under 1 Year Months Days Hours Min.		8. Date of Birth (Month, Day, Year)		9. Birthplace (State or Foreign Country)	
493-68-9366		46 Yrs.			Oct 1, 1960		Missouri		
Usual Residence of Decedent		10a. State Md				10b. County Balto.			
		10c. City, Town or Location Lochearn				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
10e. Street and Number		10f. Zip Code 3641 Forest Hill Rd. 21207				10g. Citizen of What Country? U.S.A.			
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:				13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: Black			
14. Race - American Indian, Black, White, etc. Specify: Black									
15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)				16b. Kind of Business/Industry laborer electrical			
Elementary/Secondary (0-12) 12		College (1-4 or 5+) 2							
17. Father's Name (First, Middle, Last) Jessie Earl Delaney		18. Mother's Name (First, Middle, Maiden Surname) Cecilia Palmer							
19a. Informant's Name/Relationship (Type, Print) Andrea Mahoney		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1909 Tremont St. S.E. Wash. D.C. 20020							
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Greenmount Crematory				Date 4-25-2007		20c. Location - City or Town, State Balto. Md.	
21. Signature of Funeral Service Licensee ► Carlton C. Douglass		22. Name and Address of Facility Carlton C. Douglass Funeral Service 1701 McCullough St. Balto. Md. 21217 P.A.							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Sleep apnea Chronic pain syndrome				23c. If yes, outcome pf pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown <input type="checkbox"/> Other (Specify)			
						23d. Date of delivery Month Day Year			
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown						23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown			
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)				28b. Time of Injury		28c. Injury at Work? M <input type="checkbox"/> Yes <input type="checkbox"/> No	
5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined								28d. Describe how injury occurred	
28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)								28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								29d. Date signed (Month, Day, Year) April 12 2007	
29b. Signature and title of certifier ► J Boston MD		29c. License number D28462							
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) J Boston Northwest Hospital Center Randallstown, Maryland									
31. Date filed (Month, Day, Year) APR 18 2007		32. Registrar's Signature Lisa B. [Signature]							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2007 12342
Reg. No.1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>Elmer T. Dunn</i>								2. Date of Death Month Day Year <i>04 08 07</i>	3. Time of Death <i>09:02 PM</i>
	4a. Facility Name (If not institution, give street and number) <i>Good Samaritan Hosp.</i>				4b. City, Town, or Location of Death <i>Baltimore</i>				4c. County of Death <i>N/A</i>	
Funeral Director	5. Social Security Number <i>216-36-6969</i>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <i>72</i>	If Under 1 Year Months <i>0</i>	If Under 24 Hrs. Days <i>0</i>	Hours <i>0</i>	Min. <i>0</i>	8. Date of Birth (Month, Day, Year) <i>8-28-1934</i>	9. Birthplace (State or Foreign Country) <i>Maryland</i>	
Usual Residence of Decedent 10a. State <i>Md</i> 10b. County <i>N/A</i> 10c. City, Town or Location <i>Baltimore</i> 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										
To Be Completed by Funeral Director	10e. Street and Number <i>5610 York Rd.</i>				10f. Zip Code <i>21222</i>				10g. Citizen of What Country? <i>U.S.A.</i>	
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: <i>1950</i>			13. Was Decedent of Hispanic Origin? (Specify Yes or No if Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: <i>White</i>			14. Race - American Indian, Black, White, etc. Specify: <i>White</i>	
	15. Decedent's Education (Specify only highest grade completed) <i>Elementary/Secondary (0-12)</i>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Custodian</i>				16b. Kind of Business/Industry <i>Janitorial</i>	
	17. Father's Name (First, Middle, Last) <i>Joseph M. Dunn</i>				18. Mother's Name (First, Middle, Maiden Surname) <i>Myrtle Myers</i>					
	19a. Informant's Name/Relationship (Type, Print) <i>Venitta McCray Guardian</i>				19b. Mailing Address (Street and Number Rural Route Number, City or Town, State, Zip Code) <i>10 N. Calvert St. Baltimore 21202</i>					
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <i>Mt. Carmel Cem.</i>		20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Mt. Carmel Cem.</i>			Date <i>4-20-2007</i>	20c. Location - City or Town, State <i>Baltimore, MD 21217 P.A.</i>			
	21. Signature of Funeral Service Licensee <i>Carlton C. Douglass</i>		22. Name and Address of Facility <i>Carlton C. Douglass Funeral Service</i>							
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last									
	<p>a. <i>Cardiac Arrest</i> Due to (or as a consequence of):</p> <p>b. <i>Hypocalcemia</i> Due to (or as a consequence of):</p> <p>c. <i>Metastatic prostate cancer</i> Due to (or as a consequence of):</p> <p>d. _____</p>									
	If FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Unknown						23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Dementia, Mental Retardation</i>										
23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown										
23f. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										
23g. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred				
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)						
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29c. License number <i>64493</i>								
29b. Signature and title of certifier <i>MD</i>		29d. Date signed (Month, Day, Year) <i>04-12-07</i>								
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Yojana Sange 821 N. Eutaw Street, # 308, Baltimore, MD 21201</i>										
31. Date filed (Month, Day, Year) <i>APR 18 2007</i>		32. Registrar's Signature <i>[Signature]</i>								

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached (or use as the burial-transit once).

Medical Certification; To Be Completed by Physician/Medical Examiner

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 12343

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Richard John Dahlgren						2. Date of Death Month 04 Day 14 Year 2007	3. Time of Death 6:55 P.M.		
	4a. Facility Name (If not institution, give street and number) FRANKLIN Square Hospital			4b. City, Town, or Location of Death ROSEDALE			4c. County of Death BALTIMORE			
Funeral Director	5. Social Security Number 499-32-6000	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 76 Yrs.	If Under 1 Year Months 3	If Under 24 Hrs. Hours 5	Min. 0	8. Date of Birth (Month, Day, Year) May 26, 1930	9. Birthplace (State or Foreign Country) Missouri		
	Usual Residence of Decedent 10a. State Maryland 10b. County Baltimore			10c. City, Town or Location Dundalk			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
To Be Completed by Funeral Director	10e. Street and Number 7856 Charlesmont Road			10f. Zip Code 21222			10g. Citizen of What Country? United States			
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: 3/51- 3/54		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: White		14. Race - American Indian, Black, White, etc. Specify: White			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Data Processor		16b. Kind of Business/Industry Technician					
	17. Father's Name (First, Middle, Last) Frank John Dahlgren				18. Mother's Name (First, Middle, Maiden Surname) Mabel Frederick					
Physician /Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Richard D. Dahlgren (Son)			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 205 Regent Drive Bel Air, Maryland 21014						
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) Gardens of Faith			20b. Place of Disposition (Name of cemetery, crematory or other place) Gardens of Faith		Date 4/18/2007	20c. Location - City or Town, State Baltimore, Maryland			
	21. Signature of Funeral Service Licensee Richard D. Dahlgren			22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Avenue Dundalk, Maryland 21222						
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death	
	<p>a. RESPIRATORY FAILURE Due to (or as a consequence of): PNEUMONIA</p> <p>b. COPD Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. Due to (or as a consequence of):</p>									
	23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown			23c. If yes, outcome pf pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year			
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CAD AFIB CHF DUT								23e. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide			28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred			
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.			29c. License number D64408						29d. Date signed (Month, Day, Year) 4/16/07
	29b. Signature and title of certifier DR AJAY BEHARI			29c. License number D64408						29d. Date signed (Month, Day, Year) 4/16/07
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR AJAY BEHARI 9000 FRANKLIN SQUARE DRIVE BALTIMORE MARYLAND 21237									
	31. Date filed (Month, Day, Year) APR 18 2007			32. Registrar's Signature John B. Jones						

Baltimore, Maryland 21215-0036

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division or Vital Records, P.O. Box 68760, wj

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2007 12344
Certificate of Death

Reg. No.

1- For
State
RegistrarPhysician
/Medical
ExaminerFuneral
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death 11:45 PM	
Richard Allen Davison Sr.		04 09 2007	
4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death Silver Spring		
Holy Cross Hospital		4c. County of Death Montgomery	
5. Social Security Number 440-24-3467	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 80 Yrs.	
		If Under 1 Year Months Days Hours Min.	
		8. Date of Birth (Month, Day, Year) 2-18-1927	9. Birthplace (State or Foreign Country) Oklahoma
Usual Residence of Decedent			
10a. State MD	10b. County Montgomery	10c. City, Town or Location Takoma Park	
10e. Street and Number 6833 Eastern Ave. Apt. 24		10f. Zip Code 20912	
10g. Citizen of What Country? USA			
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: UNKNOWN	13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc. 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+)	16b. Kind of Business/Industry Securities Analyst	
17. Father's Name (First, Middle, Last) Airsteen Davison		18. Mother's Name (First, Middle, Maiden Surname) Loureighn Fisher	
19a. Informant's Name/Relationship (Type, Print) Richard Davison Jr. /son		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8680 Flowering Cherry Ln. Laurel, MD 20723	
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Crownsville Veterans Cem. 4-20-07	
20c. Location - City or Town, State MD 20910			
21. Signature of Funeral Service Licensee Rapp Funeral & Crem. Svc 933 Gist Av Silver Spring			

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.			Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)			
a. Respiratory Arrest Due to (or as a consequence of):			
b. Advanced Cancer Due to (or as a consequence of):			
c. Due to (or as a consequence of):			
d. Due to (or as a consequence of):			
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) _____	23d. Date of delivery Month Day Year
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.			
23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown			
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)	
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)	28b. Time of Injury M
		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	
28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29c. License number D32247	
29b. Signature and title of certifier N. Farr		29d. Date signed (Month, Day, Year) 4/10/07	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N. Farr M. D 1500 Forest Glen Rd. Silver Spring, MD			
31. Date filed (Month, Day, Year) APRIL 8 2007		32. Registrar's Signature John S. Fisher	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2007 12345

1-For State
Registrar

Physician/ Medical Examiner	1. Decedent's Name (First, Middle, Last) LEON DICKEY					2. Date of Death Month Day Year April 15, 2007	3. Time of Death 0034 hrs
	4a. Facility Name (if not institution, give street and number) St. Agnes Hospital			4b. City, Town, or Location of Death Baltimore		4c. County of Death N/A	
Funeral Director	5. Social Security Number 251-76-9249	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 59 Yrs.	If Under 1 Year Months Days Hours Min.	8. Date of Birth (MM/DD/YYYY) SEPT. 01, 1947	9. Birthplace (State or Foreign Country) S.C.	
	Usual Residence of Decedent 10a. State MARYLAND 10b. County N/A			10c. City, Town or Location BALTIMORE CITY			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
To Be Completed by Funeral Director	10e. Street and Number 962 WHITMORE AVENUE			10f. Zip Code 21216	10g. Citizen of What Country? USA.		
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No specify: Specify: BLACK
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11TH GRADE			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) BRICK MASON			16b. Kind of Business/Industry CONSTRUCTION CO.	
17. Father's Name (First, Middle, Last) LEONIS DICKEY			18. Mother's Name (First, Middle, Maiden Surname) IDA McDOWELL				
19a. Informant's Name/Relationship (Type, Print) ALICE D. DICKEY (WIFE)			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 902 WHITMORE AVE., BALTIMORE, MD 21216				
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other Specify Jacqueline L. Leare			20b. Place of Disposition (Name of cemetery, crematory or other place) WESTERN STAR CEME			Date 04-21-07 20c. Location - City or Town, State CATONSVILLE, MD.	
21. Signature of Funeral Service Licensee Jacqueline L. Leare			22. Name and Address of Facility JOSEPH H. BROWN JR. FUNERAL HOME 2140 N. FULTON AVE., BALTO, MD 21217				
Physician Medical Examiner	23. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. a. Hypertensive Atherosclerotic Cardiovascular Disease Due to (or as a consequence of): b. _____ Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____						
	Approximate Interval Between Onset and Death						
23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown			23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No			26 Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other:			24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide			28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred	
			28e. Place of Injury - At home, farm, street, factory, office building, etc.			28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
29b. Signature and title of certifier J. M. Titus			29c. License number O.C.M.E.			29d. Date signed (Month, Day, Year) April 15, 2007	
30. Name and address of person who completed cause of death (Item 23a) Jack Titus MD. Deputy Chief Medical Examiner 111 Penn Street, Baltimore, MD 21201							
31. Date filed (Month, Day, Year) APR 18 2007			32. Registrar's Signature Leanne B. Farley			ORIGINAL	

Division of Vital Records, P.O. Box 68760, Baltimore, MD 21215-0036
 To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
 Importamt: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 12346

1- For
State
Registrar

Physician
/Medical
Examiner

Funeral
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

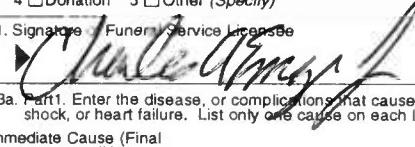
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Item 27 is marked other than "natural", or Item 23a or 28a-4 show any injury or other traumatic event. The Medical Examiner shall be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

DeBardi, Jeanette

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached (or use as the burial/transit

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year				3. Time of Death	
Jeanette Regina DeBardi		04 12 2007				8PM M	
4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of Death				4c. County of Death	
Bel Air Health and Rehabilitation Ctr.		Bel Air				Harford	
5. Social Security Number		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 79 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Hours	8. Date of Birth (Month, Day, Year) Oct. 19, 1927	9. Birthplace (State or Foreign Country) West Virginia
Usual Residence of Decedent		10a. State Maryland 10b. County Harford 10c. City, Town or Location Bel Air				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number 803 Winslow Court		10f. Zip Code 21015				10g. Citizen of What Country? USA	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Beautician				16b. Kind of Business/Industry Cosmetology	
17. Father's Name (First, Middle, Last) Ralph (nmn) DeBardi		18. Mother's Name (First, Middle, Maiden Surname) Anna (nmn) Palumbo					
19a. Informant's Name/Relationship (Type, Print) Donald Rook - Son		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 803 Winslow Court, Bel Air, MD 21015					
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Hilltop Service Corp.		Date 4/16/07	20c. Location - City or Town, State Towson, Maryland		
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility McComas Funeral Home, P.A. 50 W Broadway, Bel Air, MD 21014					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		23b. Due to (or as a consequence of): <i>Pneumonia</i>				Approximate Interval Between Death and Death 70 days	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		<p>a. Due to (or as a consequence of):</p> <p>b. Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. Due to (or as a consequence of):</p>					
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown				23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23e. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29c. License number D34652				29d. Date signed (Month, Day, Year) Apr 13, 2007	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Scott Paswill 2 North Avenue Bel Air Maryland 21014		31. Date filed (Month, Day, Year) APR 18 2007				32. Registrar's Signature 	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 12347

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) ELOUISE C. DUNCAN							2. Date of Death Month Day Year April 3, 2007	3. Time of Death 11:30 PM	
	4a. Facility Name (If not institution, give street and number) SHADY GROVE ADVENTIST HOSPITAL				4b. City, Town, or Location of Death GAITHERSBURG			4c. County of Death MONTGOMERY		
Funeral Director	5. Social Security Number 152-14-2661		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 90 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Jan. 21, 1917	9. Birthplace (State or Foreign Country) N.J.		
	Usual Residence of Decedent Md.		10a. State Md.		10b. County Montgomery			10c. City, Town or Location Montgomery Village		10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No
To Be Completed by Funeral Director	10e. Street and Number 9809 Dellcastle Rd.				10f. Zip Code 20886			10g. Citizen of What Country? United States		
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: Black			14. Race - American Indian, Black, White, etc. Specify: Black		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 5+				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Nurse			16b. Kind of Business/Industry Health		
	17. Father's Name (First, Middle, Last) John W.P. Collier					18. Mother's Name (First, Middle, Maiden Surname) Elouise Collier				
	19a. Informant's Name/Relationship (Type, Print) Henry B. Duncan / Son				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9809 Dellcastle Rd. Montgomery Village, Md. 20886					
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Chesapeake Crematory		Date 4-16-07	20c. Location - City or Town, State Beltsville, Md.				
	21. Signature of Funeral Service Licensee John W.P. Collier				22. Name and Address of Facility Capitol Mortuary, Inc. 1425 Maryland Ave., NE Wash., DC 20002					
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Aspiration pneumonia				Approximate Interval Between Onset and Death 8 days					
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Acute respiratory failure									
	c. Atrial fibrillation Due to (or as a consequence of): It hypertension									
	d.									
Physician /Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome pf pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 4 <input type="checkbox"/> Pregnant at time of death 9 <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year					
Medical Certification: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Acute renal failure coronary artery Disease				23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown					
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year) 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) At home		28f. Location (Street and Number or Rural Route Number, City or Town, State) MD					
	29b. Signature and title of certifier V. Gentile		29c. License number D41162 MD		29d. Date signed (Month, Day, Year) April 4 2007					
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) V. Gentile 19529 Doctors Drive Germantown MD 20874									
	31. Date filed (Month, Day, Year) APR 18 2007		32. Registrar's Signature Patricia L. Gentile							

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 12348

1- For State Registrar

Physician /Medical Examiner

Funeral Director

To Be Completed by Funeral Director

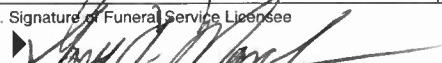
Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or items 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year		3. Time of Death	
Henry H. Davis		April 16 2007		1940 PM	
4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of Death		4c. County of Death	
North west Hospital		Randallstown		Baltimore	
5. Social Security Number		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 77 Yrs.	8. Date of Birth (Month, Day, Year) July 20, 1929	9. Birthplace (State or Foreign Country) South Carolina
10a. State md		10b. County Baltimore		10c. City, Town or Location Randallstown	
10e. Street and Number 7908 Dunhill		10f. Zip Code 21244		10g. Citizen of What Country? USA	
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: 1944		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 2 yrs -		16b. Kind of Business/Industry Stationary Engineer	
17. Father's Name (First, Middle, Last) John Davis		18. Mother's Name (First, Middle, Maiden Surname) Ethel Cooper		19a. Informant's Name/Relationship (Type, Print) Ethel L. Davis - wife	
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7908 Dunhill Village Cir. Randallstown, md.		20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) King mem. PK	
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Gary P. March Funeral Home		23a. If 11. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Immediat Cause (Final disease or condition resulting in death) Staphylococcus aureus sepsis	
23b. If female: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome pf pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Acute renal failure on chronic kidney disease Diabetes mellitus Cardiomyopathy Cellulitis right foot					
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA		23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred
		28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier 		29c. License number D 35844		29d. Date signed (Month, Day, Year) April 16 2007	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) D Roggen 5400 Old Court Road Randallstown MD 21133					
31. Date filed (Month, Day, Year) APR 18 2007		32. Registrar's Signature 			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 12349

1- For
State
Registrar

Physician
/Medical
Examiner

Funeral
Director

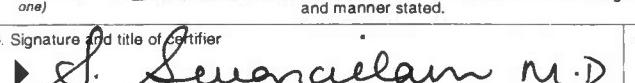
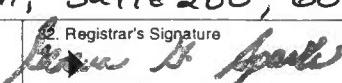
To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-1 show
any injury or other traumatic event, the Medical Examiner must be notified at
once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Baltimore, Maryland 21215-0036

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year		3. Time of Death
Richard Curlett Emerson		April 16, 2007		8:40 A M
4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of Death		4c. County of Death
2019 Brandy Drive		Forest Hill		Harford
5. Social Security Number 217-34-8211		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) 70 Yrs.	8. Date of Birth (Month, Day, Year) Mar. 9, 1937
9. Birthplace (State or Foreign Country) Maryland		10. Usual Residence of Decedent Maryland Harford		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
10e. Street and Number 2019 Brandy Drive		10f. Zip Code 21050		10g. Citizen of What Country? USA
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:
14. Race - American Indian, Black, White, etc. White		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 4		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Manager
16b. Kind of Business/Industry Phone Company		17. Father's Name (First, Middle, Last) Roy Deshazo Emerson		18. Mother's Name (First, Middle, Maiden Surname) Edith Maud Curlett
19a. Informant's Name/Relationship (Type, Print) Carol Lee Emerson/Wife		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2019 Brandy Drive, Forest Hill, Maryland 21050		20c. Location - City or Town, State
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Bel Air Memorial		Date 4-19-07
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Rd., Abingdon, Maryland 21009		20c. Location - City or Town, State
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		23b. Due to (or as a consequence of): <i>Metastatic gastric cancer</i>		Approximate Interval Between Onset and Death 1 Year
23c. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		23d. Date of delivery Month Day Year		
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) _____ 9 <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
		28d. Describe how injury occurred		28e. Location (Street and Number or Rural Route Number, City or Town, State)
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				
29b. Signature and title of certifier 		29c. License number D45530		29d. Date signed (Month, Day, Year) 4-17-07
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) S. SIVASALAM, SUITE 200, 602 S ATWOOD, BELAIR, MD 21014		31. Date filed (Month, Day, Year) APR 18 2007		32. Registrar's Signature 

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For Amend #6 Per FH G866 4/18/07 JH
State Registrar

Certificate of Death

Reg. No.

2007 12350

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last)						2. Date of Death Month Day Year	3. Time of Death Hour Min			
	Carroll Evans			Baltimore			4c. County of Death MD				
Funeral Director	4a. Facility Name (If not institution, give street and number) SAIN T AGNES HOSPITAL			4b. City, Town, or Location of Death Baltimore			4c. County of Death MD				
	5. Social Security Number 212-44-4471	6. Sex M	7. Age (In yrs. last birthday) 61 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) 4-6-1946	9. Birthplace (State or Foreign Country) MD				
To Be Completed by Funeral Director	10a. State MD			10b. County NA			10c. City, Town or Location Baltimore		10d. Inside City Limits X Yes 2 No		
	10e. Street and Number 1722 N. Register Street			10f. Zip Code 21213			10g. Citizen of What Country? U S A				
Physician /Medical Examiner	11. Marital Status 1 Never Married 2 Married		12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No Specify:			14. Race - American Indian, Black, White, etc. Specify: Black			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10th grade		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Dietary Aide		16b. Kind of Business/Industry Montebello State Hospital						
17. Father's Name (First, Middle, Last) Walter Evans					18. Mother's Name (First, Middle, Maiden Surname) Rosa Allen						
19a. Informant's Name/Relationship (Type, Print) George Evans - Brother					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1722 N. Register Street Balto, MD 21213						
20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)					20b. Place of Disposition (Name of cemetery, crematory or other place) Trinity Cemetery		Date 4-20-2007	20c. Location - City or Town, State Balto, MD			
21. Signature of Funeral Service Licensee M lady Wane					22. Name and Address of Facility March F/H East 1101 E. North Avenue Balto, MD 21202						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last					Approximate Interval Between Onset and Death i hours 2 hours 2 days						
23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown		23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown					23d. Date of delivery Month Day Year				
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CERERAL VASCULAR ACCIDENT					23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown						
25. Was case referred to medical examiner? 1 Yes 2 No		26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA			Other: 4 Nursing Home 5 Residence 6 Other (Specify)		24a. Was an autopsy performed? 1 Yes 2 No			24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No	
27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide		28a. Date of Injury (Month, Day Year) 5 Pending investigation		28b. Time of Injury M		28c. Injury at Work? 1 Yes 2 No		28d. Describe how injury occurred			
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier Jerome I. Snyder, M.D.									
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jerome I. Snyder, M.D., 10 SOUTH CATION AVENUE BALTIMORE, MAR 21229		29c. License number D22648		29d. Date signed (Month, Day, Year) APRIL 15, 2007							
31. Date filed (Month, Day, Year) APR 18 2007		32. Registrar's Signature Jerome I. Snyder									

Baltimore, Maryland 21215-0036
Division of Vital Records, P.O. Box 68760,
Evans, Carroll

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", the Medical Examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2007 12351

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Pauline Fitez				2. Date of Death Month Day Year April 16 2007	3. Time of Death 5:20 P M
	4a. Facility Name (If not institution, give street and number) 425 Cedar Hill Road		4b. City, Town, or Location of Death Brooklyn Park		4c. County of Death Anne Arundel County	
Funeral Director	5. Social Security Number 214-38-2612	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 66 Yrs.	If Under 1 Year Months Days Hours Min.	8. Date of Birth (Month, Day, Year) Oct 21, 1940	9. Birthplace (State or Foreign Country) Maryland
	Usual Residence of Decedent Maryland Anne Arundel		10c. City, Town or Location Glen Burnie			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
To Be Completed by Funeral Director	10e. Street and Number 200 Juniper Drive			10f. Zip Code 21060	10g. Citizen of What Country? USA	
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: Year or Dates:	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: White		14. Race - American Indian, Black, White, etc. Specify: White
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Retail	16b. Kind of Business/Industry KMart Dept. Store		
	17. Father's Name (First, Middle, Last) Wilbur Carroll Wilson, Sr.			18. Mother's Name (First, Middle, Maiden Surname) Emma Gertrude Scheiddeger		
	19a. Informant's Name/Relationship (Type, Print) Jacqueline Whitten (Daughter)			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 200 Juniper Drive, Glen Burnie, Maryland 21060		
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) Kevin E Ecker		20b. Place of Disposition (Name of cemetery, crematory or other place) Crestlawn Mem Gdns	Date 4/20/07	20c. Location - City or Town, State Marriottsville, Maryland	
	21. Signature of Funeral Service Licensee 			22. Name and Address of Facility McCully-Polyniak Funeral Home, P.A. 237 E. Patapsco Ave., Balto., Md. 21225-1856		
Physician /Medical Examiner	<p>23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.</p> <p>Immediate Cause (Final disease or condition resulting in death)</p> <p>{</p> <p>a. Due to (or as a consequence of): Partial Bowel Obstruction</p> <p>b. Due to (or as a consequence of): Post Radiation Surgery Adhesion</p> <p>c. Due to (or as a consequence of): Colon Cancer</p> <p>d.</p> <p>Approximate Interval Between Onset and Death 6 mos</p> <p>6 mo</p> <p>4 years</p>					
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown <input type="checkbox"/> Other (Specify) _____	23d. Date of delivery Month Day Year		
	<p>Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.</p> <p>Cirrhosis of liver, Atrial fibrillate</p> <p>23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown</p>					
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		<p>26. Place of Death (Check only one) <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) SISTER'S RESIDENCE</p>			
	27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred
			28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
	<p>29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.</p> <p>29b. Signature and title of certifier </p> <p>29c. License number 330555</p> <p>29d. Date signed (Month, Day, Year) April 17, 2007</p>					
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Alan N. Scanni 901 East Kart Ave Baltimore MD 21230					
State Registrar	31. Date filed (Month, Day, Year) APR 18 2007		32. Registrar's Signature 			

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

5 2

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
 Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amend #19a per FH g866 4/18/07 JH

Certificate of Death

2007 12352

**Physician/
Medical Examiner**

1- For State
Registrar

1. Decedent's Name (First, Middle, Last)

Martin Farmer

Reg. No.

2. Date of Death
Month Day Year
April 14, 20073. Time of Death
2132 hrs

**Funeral
Director**

97A

1a. Facility Name (if not institution, give street and number)

Johns Hopkins Hospital

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

14. Social Security Number

218-58-4339

15. Sex

 M F

16. Age (In yrs. last birthday)

5517. If Under 1 Year
Months Days18. If Under 24 Hrs.
Hours Min.19. Date of Birth (MM/DD/YYYY)
08/18/195120. Birthplace (State or
Foreign Country)
Maryland

21. Usual Residence of Decedent

22. State

Maryland

23. County

24. City, Town or Location

Baltimore

25. Inside City Limits

 Yes No

26. Street and Number

2905 Jefferson Street

27. Zip Code

21205

28. Citizen of What Country?

U.S.A.

29. Marital Status

 Never Married Married30. Was Decedent Ever in U.S.
Armed Forces? Yes No Widowed Divorced31. If Yes, Give Year
or Dates32. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Yes No

33. Specify:

34. Race - American Indian, Black,
White, etc.35. Specify: **Black**

36. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

237. Decedent's Usual Occupation (Give kind of work done
during most of working life. DO NOT use retired)**Clerical Associate**

38. Kind of Business/Industry

Hospital

39. Father's Name (First, Middle, Last)

Sidney Farmer

40. Mother's Name (First, Middle, Maiden Surname)

Ruth Royster

41. Informant's Name/Relationship (Type, Print)

Mother
Ruth Farmer / Wife

42. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2905 Jefferson Street, Baltimore, Maryland 21205

43. Method of Disposition

 Burial Cremation Removal from State44. Place of Disposition (Name of cemetery,
crematory or other place)**King Mem. Park Ceme.**

45. Date

04/20/2007

46. Location - City or Town, State

Baltimore, Maryland

47. Signature of Funeral Service Licensee

48. Name and Address of Facility

**The Derrick C. Jones F/H, P.A.
4611 Park Hgts. Ave., Baltimore, Maryland 21215**

Baltimore, MD 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any
injury or other traumatic event, the Medical Examiner must be notified at once.

**Physician/
Medical Examiner**

To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease
or condition resulting in death)a. **Heroin intoxication**

Due to (or as a consequence of):

b. Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying Cause
(Disease or injury that initiated
events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval
Between Onset and
Death UNPENDED AMENDED

#23a, 27, 28a-f, per ME, g866, 4/30/07 TT

Division of Vital Records, P.O. Box 68760,

The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial - transit23b. Was decedent pregnant in the
past 12 months?1 Yes 2 No 9 Unknown

23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 3 Ectopic pregnancy4 Pregnant at time of death 5 Other (Specify)9 Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy performed?

24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No1 Yes 2 No25. Was case referred to medical
examiner?1 Yes 2 No

26. Place of Death (Check only one)

Hospital: 1 Inpatient 2 ER/Outpatient 3 DOAOther: 4 Nursing Home 5 Residence 6 Other

27. Manner of Death

1 Natural 5 Pending
2 Accident Investigation
3 Suicide 6 Could not be
determined
4 Homicide28a. Date of Injury
(Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

28d. Describe how injury occurred

Fnd 4/14/2007 unk 1 Yes 2 No unk

28e. Place of Injury - At home, farm, street, factory, office building, etc.

(Specify) other-scene

28f. Location (Street and Number or Rural Route Number, City
or Town, State)

2905 Jefferson St., Baltimore, MD

29a. Certifier

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

and manner stated

29b. Signature and title of certifier

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

April 15, 2007

30. Name and address of person who completed cause of death (Item 23a)

Zabiullah Ali, M.D.

Assistant Medical Examiner

111 Penn Street, Baltimore, MD 21201

31. Date filed (Month, Day, Year)

APR 18 2007

32. Registrar's Signature

State
Registrar

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 12353

1 - For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Ruth Lee Fowlkes							2. Date of Death Month Day Year April 12 2007	3. Time of Death 2:42 PM			
	4a. Facility Name (If not institution, give street and number) Good Samaritan Hospital			4b. City, Town, or Location of Death Baltimore			4c. County of Death					
Funeral Director	5. Social Security Number 241-32-4392		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 79 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) 4-12-1928	9. Birthplace (State or Foreign Country) N. C.				
	Usual Residence of Decedent 10a. State MD		10b. County NA		10c. City, Town or Location Baltimore			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				
10e. Street and Number 4015 Loch Raven Blvd				10f. Zip Code 21218			10g. Citizen of What Country? U S A					
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: 24			13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: Black				
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th grade				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Cafeteria			16b. Kind of Business/Industry Montgomery Ward					
17. Father's Name (First, Middle, Last) Oscar Boyd				18. Mother's Name (First, Middle, Maiden Surname) Ruth Jones								
19a. Informant's Name/Relationship (Type, Print) Pattie Boyd - Sister				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4015 Loch Raven Blvd Balto, MD 21218								
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) King Memorial Pk			Date 4-18-08	20c. Location - City or Town, State Randallstown, MD				
21. Signature of Funeral Service Licensee M lady W and				22. Name and Address of Facility March F/H East 1101 E. North Avenue Balto, MD 21202								
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Metastatic Breast Cancer									Approximate Interval Between Onset and Death			
<p>a. Due to (or as a consequence of): Metastatic Breast Cancer</p> <p>b. Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. _____</p>												
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown						23d. Date of delivery Month Day Year				
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Hypertension Renal failure									23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown			
									24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)										
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury		28c. Injury at Work? M 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred				
5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined												
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)									28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29c. License number RES 000							29d. Date signed (Month, Day, Year) 4/12/2007			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) L. Zhang, M.D., Good Samaritan Hospital, 5601 Loch Raven Blvd, Baltimore 21218									31. Date filed (Month, Day, Year) APR 18 2007			
									32. Registrar's Signature Ruth Lee Fowlkes			

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit slip.

Medical Certification: To Be Completed by Physician/Medical Examiner

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 12354

1- For State Registrar

Physician /Medical Examiner

Funeral Director

Baltimore, Maryland 21215-0036
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

1. Decedent's Name (First, Middle, Last) Edward L. Fortune							2. Date of Death Month April Day 08 Year 2007	3. Time of Death 8:57 PM
4a. Facility Name (If not institution, give street and number) University of Maryland center medical							4b. City, Town, or Location of Death Baltimore	4c. County of Death N/A
5. Social Security Number 212-46-6666	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 60 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Hours	Min.	8. Date of Birth (Month, Day, Year) 9-20-1946	9. Birthplace (State or Foreign Country) MD	
Usual Residence of Decedent 10a. State MD 10b. County NA 10c. City, Town or Location Balto							10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number 511 Archer Street				10f. Zip Code 21230			10g. Citizen of What Country? U S A	
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: Specify: Black			14. Race - American Indian, Black, White, etc. Specify: Black	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th grade			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Disabled			16b. Kind of Business/Industry NA		
17. Father's Name (First, Middle, Last) Nelson Fortune, Sr				18. Mother's Name (First, Middle, Maiden Surname) Maryland Scales				
19a. Informant's Name/Relationship (Type, Print) Trea Fortune - Wife			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 511 Archer Street Balto, MD 21230					
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input checked="" type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Mt Carmel Cemetery			Date 4-17-07	20c. Location - City or Town, State Balto, MD	
21. Signature of Funeral Service Licensee Gladys Warner			22. Name and Address of Facility March East F/H 1101 E. North Avenue Balto, MD 21202					

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Hepatitis C		Approximate Interval Between Onset and Death			
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last {					
a. Due to (or as a consequence of): Hepatitis C					
b. Due to (or as a consequence of):					
c. Due to (or as a consequence of):					
d. Due to (or as a consequence of):					
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown	23c. If yes, outcome pf pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown	23d. Date of delivery Month Day Year			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					
23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown					
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier M.D.	29c. License number AV4176435N16686			29d. Date signed (Month, Day, Year) April 08 2007	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PENAU NOTICEWANT 22 South Greene Street Baltimore MD 21201					
31. Date filed (Month, Day, Year) APR 18 2007	32. Registrar's Signature John B. Mullis				

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2007 12355

1- For State Registrar

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)

Evelyn Marie Gordon

2. Date of Death

Month

Day

Year

APR 16 2007

3. Time of Death

1252 PM

Funeral Director

4a. Facility Name (If not institution, give street and number)

St. Agnes Hospital

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

5. Social Security Number

6. Sex

 M F

7. Age (In yrs. last birthday)

87

Yrs.

If Under 1 Year

Months

Days

Hours

Min.

8. Date of Birth

(Month, Day, Year)

Year

Feb. 2, 1920

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

10b. County

10c. City, Town or Location

10d. Inside City Limits

Maryland

N/A

Baltimore

 Yes No

10e. Street and Number

2420 W. Lanvale Street

10f. Zip Code

21216

10g. Citizen of What Country?

USA

11. Marital Status

 Never Married Married
 Widowed Divorced

12. Was Decedent Ever in U.S. Armed Forces?

 Yes No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
 Yes No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Housewife

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

John Lonesome

18. Mother's Name (First, Middle, Maiden Surname)

Veronica Williams

19a. Informant's Name/Relationship (Type, Print)

Gina Marie Jones/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2420 W. Lanvale St. Baltimore, Maryland 21216

20a. Method of Disposition

 Burial Cremation Removal from State
 Donation Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Loudon Park Cemetery

Date
4/23/07

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Chatman-Harris Funeral Home
5240 Reisterstown Rd Baltimore, Md 21215

23a. Part I Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Approximate Interval Between Onset and Death

Hours

Hypoxic Respiratory Failure

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

Chronic Obstructive Pulmonary Disease Years

Due to (or as a consequence of):

Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?
 Yes No
 Unknown

23c. If yes, outcome pf pregnancy

 Live birth Fetal death
 Pregnant at time of death
 Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Peripheral Vascular Disease

Retroperitoneal bleed

23e. Did tobacco use contribute to the cause of death?

 Yes No Probably Unknown

25. Was case referred to medical examiner?

 Yes No

26. Place of Death (Check only one)

Hospital: Inpatient ER/Outpatient DOA Other: Nursing Home Residence Other (Specify)

27. Manner of Death

1. Natural
2. Accident
3. Suicide
4. Homicide

5. Pending investigation

6. Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

 Yes No

28d. Describe how injury occurred

29a. Certifier (Check only one): To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
29b. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

P20556

29d. Date signed (Month, Day, Year)

APR 16 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Lesbeth N Cloutier 9005 Caton AVE, Baltimore MD 21229

31. Date filed (Month, Day, Year)

APR 18 2007

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2007 12356

1 - For State Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Margaret Lula Goodwin					2. Date of Death Month Day Year April 10, 2007	3. Time of Death 6:30 P.M.	
	4a. Facility Name (If not institution, give street and number) Suburban Hospital			4b. City, Town, or Location of Death Bethesda		4c. County of Death Montgomery		
Funeral Director	5. Social Security Number 230-28-3773	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 78 Yrs.	If Under 1 Year Months Days Hours Min.	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Nov. 11, 1928	9. Birthplace (State or Foreign Country) Virginia	
To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State MD. 10b. County Montgomery 10c. City, Town or Location Bethesda						10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	10e. Street and Number 5015 Battery Lane-Apt. #1001			10f. Zip Code 20814		10g. Citizen of What Country? United States of America		
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: X		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: White		14. Race - American Indian, Black, White, etc. Specify: White		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 2 College (1-4 or 5+) 2		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Administrative Officer			16b. Kind of Business/Industry US Dept. of Labor		
	17. Father's Name (First, Middle, Last) Mason Scott			18. Mother's Name (First, Middle, Maiden Surname) Elizabeth Wilmouth				
	19a. Informant's Name/Relationship (Type, Print) Joyce Foster-Daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7657 Michelle Court-Manassas, Virginia 20109			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) X		20b. Place of Disposition (Name of cemetery, crematory or other place) Stonewall Memory Gdns. 4-14-2007		Date	20c. Location - City or Town, State Manassas, Virginia		
	21. Signature of Funeral Service Licensee Open Blendle				22. Name and Address of Facility Pierce-Price Funeral Home, Inc. 9609 Center Street-Manassas, Virginia 20110			
	23a. Part I: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Metastatic Gastric Cancer Approximate Interval Between Onset and Death							
	a. Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):							
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome pf pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year		
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Hypercalcemia							
	23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown							
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No			
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred		
			28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)		
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
	29b. Signature and title of certifier Natalie Haag, MD				29c. License number D62949		29d. Date signed (Month, Day, Year) April 11, 2007	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Natalie Haag, MD Old Georgetown Rd. Bethesda, MD							
State Registrar	31. Date filed (Month, Day, Year) APR 18 2007		32. Registrar's Signature Susan B. Speer					

Baltimore, Maryland 21215-0036
 Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
 Important: If item 27 is marked other than "natural", or items 23a or 28a show any injury or other traumatic event, the Medical Examiner must be notified at once.

MARGARET GOODWIN
 Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

4 10/07 18:26 PM.

10

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 12357

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last)							2. Date of Death Month Day Year	3. Time of Death
	JUNE ILEANA GREEN							APRIL 14, 2007	8:30 P M
Funeral Director	4a. Facility Name (If not institution, give street and number)			4b. City, Town, or Location of Death			4c. County of Death		
	NORTHAMPTON MANOR HEALTH CARE			FREDERICK			FREDERICK		
5. Social Security Number		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 73 Yrs.	If Under 1 Year Months	II Under 24 Hrs. Days	Hours	Min.	8. Date of Birth (Month, Day, Year) 2/27/1934	9. Birthplace (State or Foreign Country) MARYLAND
Usual Residence of Decedent									
10a. State MD	10b. County CARROLL	10c. City, Town or Location MT. AIRY						10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number 5938 RIDGE RD.				10f. Zip Code 21771			10g. Citizen of What Country? USA		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: WHITE
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+)			16b. Kind of Business/Industry HOUSEWIFE			HOME MAKER
17. Father's Name (First, Middle, Last) EMIL A. CAPLE					18. Mother's Name (First, Middle, Maiden Surname) EMMA LaRUE SHAMER				
19a. Informant's Name/Relationship (Type, Print) HUSBAND WILLIAM S. GREEN, SR.			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5938 RIDGE RD., MT. AIRY, MD 21771			Date			20c. Location - City or Town, State
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) PATAPSICO CEMETERY			4/19/07			PATAPSICO, MD
21. Signature of Funeral Service Licensee 			22. Name and Address of Facility FLETCHER FUNERAL HOME, P.A. 254 E. MAIN ST., WESTMINSTER, MD 21157						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) COPD									Approximate Interval Between Onset and Death
a. Due to (or as a consequence of): CONGESTIVE HEART DISEASE									
b. Due to (or as a consequence of):									
c. Due to (or as a consequence of):									
d. _____									
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____ <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year				
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29b. Signature and title of certifier 		29c. License number D 47951			29d. Date signed (Month, Day, Year) 4-16-2007				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SIBTE A KARMI, MD 814 TOW HOUSE AVE. FREDERICK MD 21701					32. Registrar's Signature 				
31. Date filed (Month, Day, Year) APR 18 2007					33. Date of Birth (Month, Day, Year)				

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Amend #18, per Ph, G866, 4/18/07 TT
Registrar

Certificate of Death

Reg. No. 2007 12358

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) ROBERT GREEN							2. Date of Death Month April Day 15 Year 2007	3. Time of Death 1:10 A M
	4a. Facility Name (If not institution, give street and number) 5330 DORSEY HALL DRIVE #109			4b. City, Town, or Location of Death ELLIOTT CITY			4c. County of Death HOWARD		
Funeral Director	5. Social Security Number 109-03-1982	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 90 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Hours	8. Date of Birth (Month, Day, Year) 06/10/1916	9. Birthplace (State or Foreign Country) NY		
	Usual Residence of Decedent 10a. State MD 10b. County HOWARD			10c. City, Town or Location ELLIOTT CITY			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
To Be Completed by Funeral Director	10e. Street and Number 5330 DORSEY HALL DRIVE #109			10f. Zip Code 21042			10g. Citizen of What Country? U.S.A.		
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: 1916			13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: White			14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) CHIEF			16b. Kind of Business/Industry FIRE DEPARTMENT		
	17. Father's Name (First, Middle, Last) ABRAHAM GREEN			18. Mother's Name (First, Middle, Maiden Surname) ADNAS Agnas GUMMPEL					
Physician /Medical Examiner	19a. Informant's Name/Relationship (Type, Print) MOLLIE GREEN / WIFE			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5330 DORSEY HALL DRIVE #109-ELLIOTT CITY, MD 21042					
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) COLUMBIA MEMORIAL PARK			20b. Place of Disposition (Name of cemetery, crematory, or other place) COLUMBIA MEMORIAL PARK			Date 04/17/2007	20c. Location - City or Town, State COLUMBIA, MD	
	21. Signature of Funeral Service Licensee 			22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Myocardial infarction Approximate Interval Between Onset and Death 1 day								
	a. Due to (or as a consequence of): Myocardial infarction								
	b. Due to (or as a consequence of):								
	c. Due to (or as a consequence of):								
	d. Due to (or as a consequence of):								
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown			23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) Unknown			23d. Date of delivery Month Day Year		
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Dementia Sick sinus syndrome								
	23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown								
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
	27. Manner of Death 1 Natural 5 Pending investigation 2 Accident 6 Could not be determined			28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred		
				28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)		
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
	29b. Signature and title of certifier 								
	29c. License number D 37013								
	29d. Date signed (Month, Day, Year) April 16, 2007								
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bruce M. Congrus 6205 11058 Little Rexert Hwy Columbia MD 21046								
	31. Date filed (Month, Day, Year) APR 18 2007			32. Registrar's Signature 					

Baltimore, Maryland 21215-0036

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division or Vital Records, P.O. Box 68760, 

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

12

State Registrar

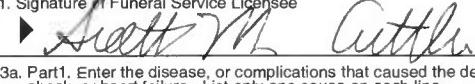
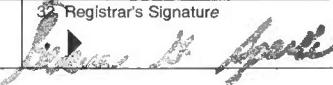
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1 - For State Amend #4a, 26, per MD, g866, 4/18/07 TT Certificate of Death

Reg. No.

2007 12359

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) MARGARET GOLDSTEIN			2. Date of Death Month APRIL Day 13 Year 2007	3. Time of Death 8:50 A M		
	4a. Facility Name (If not institution, give street and number) 3 SHIPHORST AVENUE Terrace			4b. City, Town, or Location of Death ROSEDALE		4c. County of Death BALTIMORE	
Funeral Director	5. Social Security Number 218-10-6044	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 88 Yrs.	If Under 1 Year Months 0 Days 0	If Under 24 Hrs. Hours 0 Min. 0	8. Date of Birth (Month, Day, Year) 10/07/1918	9. Birthplace (State or Foreign Country) MD
	Usual Residence of Decedent 10a. State VA 10b. County HANOVER			10c. City, Town or Location MECHANICSVILLE			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
To Be Completed by Funeral Director	10e. Street and Number 7472 HIDDEN LAKE CIRCLE			10f. Zip Code 23111		10g. Citizen of What Country? U.S.A.	
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	14. Race - American Indian, Black, White, etc. Specify: WHITE			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) HOUSEWIFE	16b. Kind of Business/Industry OWN HOME				
	17. Father's Name (First, Middle, Last) JACOB	18. Mother's Name (First, Middle, Maiden Surname) BECHTOLD DORA KLEYLEIN					
	19a. Informant's Name/Relationship (Type, Print) NORMA SLEDGE / DAUGHTER	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3 SHIPHORST TERRACE - ROSEDALE, MD 21237					
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) MARYLAND FREE STATE POST 167	20b. Place of Disposition (Name of cemetery, crematory or other place) MARYLAND FREE STATE POST 167	Date 04/15/2007	20c. Location - City or Town, State ROSEDALE, MD			
	21. Signature of Funeral Service Licensee 	22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208					
Physician /Medical Examiner	23a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Atherosclerotic Heart Disease Due to (or as a consequence of): b. Hyper tension Due to (or as a consequence of): c. Hyper cholesterolemia Due to (or as a consequence of): d.					Approximate Interval Between Onset and Death	
	23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown			23c. If yes, outcome pf pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____ <input type="checkbox"/> Unknown	23d. Date of delivery Month Day Year		
Medical Certification: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) DAUGHTERS HOUSES House			
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide			28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred
	28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.						
	29b. Signature and title of certifier 			29c. License number D0043909	29d. Date signed (Month, Day, Year) April 13, 2007		
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Stephanie Linder 902 Averill Rd Joppa, MD 21085						
State Registrar	31. Date filed (Month, Day, Year) APR 18 2007	32. Registrar's Signature 					

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2007 12361

Certificate of Death

Reg. No.

1- For State Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) CHARLES HUGHES							2. Date of Death Month APRIL Day 15TH Year 2007			3. Time of Death 15:04 M			
	4a. Facility Name (If not institution, give street and number) The Johns Hopkins Hospital			4b. City, Town, or Location of Death Baltimore City			4c. County of Death							
Funeral Director	5. Social Security Number 213-34-1079		6. Sex 1 M	7. Age (In yrs. last birthday) 68 Yrs.	If Under 1 Year Months		If Under 24 Hrs. Days Hours Min.		8. Date of Birth (Month, Day, Year) Jan. 6, 1939		9. Birthplace (State or Foreign Country) Maryland			
	Usual Residence of Decedent		10a. State Maryland		10b. County Harford		10c. City, Town or Location Bel Air		10d. Inside City Limits 1 Yes 2 No					
To Be Completed by Funeral Director	10e. Street and Number 1001 Chantry Drive					10f. Zip Code 21015			10g. Citizen of What Country? USA					
	11. Marital Status 1 Never Married 2 Married		12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No Specify:			14. Race - American Indian, Black, White, etc. Specify: White					
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)					16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+)			16b. Kind of Business/Industry Systems Manager					
	17. Father's Name (First, Middle, Last) James Russell Hughes					18. Mother's Name (First, Middle, Maiden Surname) Gladys Viola Rodgers								
	19a. Informant's Name/Relationship (Type, Print) Susan L. Hughes / Wife					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1001 Chantry Drive, Bel Air, Maryland 21015								
	20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State		20b. Place of Disposition (Name of cemetery, crematory or other place) Harford Memorial Grdn			Date 4-19-07		20c. Location - City or Town, State Aberdeen, Maryland						
	21. Signature of Funeral Service Licensee Stephen A. Wright					22. Name and Address of Facility McConas Funeral Home, P.A.			23. Name and Address of Facility 1317 Cokesbury Road, Abingdon, Maryland 21009					
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last										Approximate Interval Between Onset and Death WEEKS			
	<p>a. Due to (or as a consequence of): CENTRAL HYPOVENTILATION SYNDROME</p> <p>b. Due to (or as a consequence of): PROGRESSIVE MULTIFOCAL LEUKOENCEPHALOPATHY</p> <p>c. Due to (or as a consequence of): IMMUNOSUPPRESSION FROM LIVER TRANSPLANTATION</p> <p>d. Due to (or as a consequence of): CRYPTOGENIC UVER CIRRHOSIS</p>													
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No		23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy			23d. Date of delivery Month Day Year								
	4 Pregnant at time of death 9 Unknown		5 Other (specify) _____											
Medical Certification: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown			
											24a. Was an autopsy performed? 1 Yes 2 No	24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No		
	25. Was case referred to medical examiner? 1 Yes 2 No		26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA			Other: 4 Nursing Home 5 Residence 6 Other (Specify)								
	27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide		28a. Date of Injury (Month, Day Year) M		28b. Time of Injury M		28c. Injury at Work? 1 Yes 2 No		28d. Describe how injury occurred					
	5 Pending investigation 6 Could not be determined		28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) At home						28f. Location (Street and Number or Rural Route Number, City or Town, State) 600 NORTH WOLFE STREET, BALTIMORE, MD 21287-9106					
	29a. Certifier (Check only one) 1 Certifying Physician 2 Medical Examiner		29b. Certification Statement: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.											
	29c. License number RES-000		29d. Date signed (Month, Day, Year) APRIL 15TH 2007											
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JONATHAN BATH		31. Date filed (Month, Day, Year) APR 18 2007		32. Registrar's Signature James B. Spangler									

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division or Vital Records, P.O. Box 68760, U.S.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

12

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene
1- Amend #12 Per FHC866 4/18/07 Jh Certificate of Death 2007 12362
For State Registrar Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Joseph Hayes				2. Date of Death Month 04 Day 16 Year 2007	3. Time of Death 3:00 P M	
	4a. Facility Name (If not institution, give street and number) Future Care Nursing Home, Irvington				4b. City, Town, or Location of Death Baltimore		4c. County of Death
Funeral Director	5. Social Security Number 217-07-4287	6. Sex 1 X M	7. Age (In yrs. last birthday) Yrs. 90	If Under 1 Year Months 1944	If Under 24 Hrs. Hours 1945	8. Date of Birth (Month Day Year) 06/02/1916	9. Birthplace (State or Foreign Country) North Carolina
	Usual Residence of Decedent 10a. State Maryland				10b. County Baltimore		
To Be Completed by Funeral Director	10e. Street and Number 2652 Edmondson Avenue				10f. Zip Code 21223	10g. Citizen of What Country? U.S.A.	
Physician /Medical Examiner	11. Marital Status 3 X Widowed	12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates: 1944-1945	13. Was Decedent of Hispanic Origin? (Specify Yes or No) 1 □ Yes 2 X No Specify: Black	14. Race - American Indian, Black, White, etc. Black			
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+)	16b. Kind of Business/Industry Quality Checker				
Baltimore, Maryland 21215-0036	17. Father's Name (First, Middle, Last) Willie Hayes	18. Mother's Name (First, Middle, Maiden Surname) Unknown					
Division of Vital Records, P.O. Box 68760,	19a. Informant's Name/Relationship (Type, Print) Sandra Wright-Short / Daughter	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4806 Haddon Avenue, Baltimore, Maryland 21207					
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)	20b. Place of Disposition (Name of cemetery, crematory or other place) Garrison Forest Cemetery	Date 04/24/2007	20c. Location - City or Town, State Owings Mills, Maryland			
	21. Signature of Funeral Service Licensee	22. Name and Address of Facility The Derrick C. Jones F/H, P.A.					
		4611 Park Hgts. Ave., Baltimore, Maryland 21215					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)	Approximate Interval Between Onset and Death <i>Atherosclerotic Cardiovascular Disease</i>					
	a. Due to (or as a consequence of): <i>Cachexia</i>						
	b. Due to (or as a consequence of):						
	c. Due to (or as a consequence of):						
	d. _____						
IF FEMALE:	23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (Specify) _____	23d. Date of delivery Month Day Year					
23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown							
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
23e. Did tobacco use contribute to the cause of death? 1 □ Yes 2 □ No 3 □ Probably 4 □ Unknown							
25. Was case referred to medical examiner? 1 □ Yes 2 X No	26. Place of Death (Check only one) Hospital: 1 □ Inpatient 2 □ ER/Outpatient 3 □ COA Other: 4 X Nursing Home 5 □ Residence 6 □ Other (Specify)						
27. Manner of Death 1 X Natural 2 □ Accident 3 □ Suicide 4 □ Homicide	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 □ Yes 2 □ No	28d. Describe how injury occurred			
5 □ Pending investigation	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)					
6 □ Could not be determined							
29a. Certifier 1 □ Certifying Physician : To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 □ Medical Examiner : On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
29b. Signature and title of certifier <i>LIAQAT ALI</i>	29c. License number D47405	29d. Date signed (Month, Day, Year) 4/16/07					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LIAQAT ALI 821 N-Eutaw St. Baltimore MD 21201							
31. Date filed (Month, Day, Year) APR 18 2007	32. Registrar's Signature <i>John B. Harrel</i>						

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 12363

1- For State Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) LOUIS W. HARRIS				2. Date of Death Month APRIL Day 11 Year 2007	3. Time of Death 10:00 A M	
	4a. Facility Name (If not institution, give street and number) BON SECOURS HOSPITAL		4b. City, Town, or Location of Death BALTIMORE		4c. County of Death		
Funeral Director	5. Social Security Number 219-26-1689	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) Yrs. 70	If Under 1 Year Months 0 Days 0 Hours 0 Min. 0	8. Date of Birth (Month, Day, Year) DEC. 31, 1936	9. Birthplace (State or Foreign Country) BALTIMORE, MD	
	Usual Residence of Decedent 10a. State Md		10b. County		10c. City, Town or Location BALTIMORE		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
To Be Completed by Funeral Director	10e. Street and Number 1800 HOLLINS ST.,			10f. Zip Code 21223		10g. Citizen of What Country? UNITED STATES	
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: BLACK	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) CARPENTER		16b. Kind of Business/Industry CAPENTRY		
	17. Father's Name (First, Middle, Last) GEORGE HARRIS			18. Mother's Name (First, Middle, Maiden Surname) CATHERINE WHITE			
	19a. Informant's Name/Relationship (Type, Print) DAVID THOMPSON/NEPHEW		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9902 BASS-SIN COURT CLINTON, MD. 20735				
	20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) ST. MARY'S CHURCH CFM		20b. Place of Disposition (Name of cemetery, crematory or other place)		Date 4/18/07	20c. Location - City or Town, State BRYANTOWN, MD	
	21. Signature of Funeral Service License David Thompson Valley		22. Name and Address of Facility CAPITOL MORTUARY		1425 MARYLAND AVE., N.E. WASH., D.C. 20002		
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. (Enter only one cause on each line.) Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		Approximate Interval Between Onset and Death 8 DAYS				
	a. MULTILOBAR PNEUMONIA Due to (or as a consequence of):						
	b. CHRONIC OBSTRUCTIVE LUNG DISEASE UNKNOWN Due to (or as a consequence of):						
	c. METASTATIC CARCINOMA OF PROSTATE. Due to (or as a consequence of):						
	d. OBSTRUCTIVE JAUNDICE Due to (or as a consequence of):						
Medical Certification: To Be Completed by Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome pf pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____ <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year		
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. HYPERTENSION DIABETES MELLITUS		23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown				
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) _____				
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred	
			28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
	29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29c. License number D 23300				
	29b. Signature and title of certifier SUDHIR. PATEL		29d. Date signed (Month, Day, Year) APRIL 11 2007				
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SUDHIR. PATEL 200 W. BALTO. ST. BALTO. MD. 21223.						
State Registrar	31. Date filed (Month, Day, Year) APR 18 2007		32. Registrar's Signature J. JONES				

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed in by the funeral director, page 2 should be detached for use as the burial transit

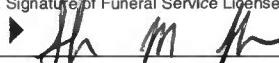
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 12364

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Evaed M. Hanes							2. Date of Death Month April Day 16 Year 2007	3. Time of Death 3:40 P M	
	4a. Facility Name (If not institution, give street and number) Montgomery Hospice Casey House			4b. City, Town, or Location of Death Rockville			4c. County of Death Montgomery			
Funeral Director	5. Social Security Number 176-01-4212	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 90 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) May 8, 1916	9. Birthplace (State or Foreign Country) Pennsylvania			
	Usual Residence of Decedent Maryland Montgomery			10c. City, Town or Location Bethesda			10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
To Be Completed by Funeral Director	10a. State Maryland			10b. County Montgomery			10c. City, Town or Location Bethesda			
	10e. Street and Number 8824 Ridge Road			10f. Zip Code 20817			10g. Citizen of What Country? United States			
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Hair Dresser			16b. Kind of Business/Industry Business Owner			
	17. Father's Name (First, Middle, Last) George Schaszberger				18. Mother's Name (First, Middle, Maiden Surname) Elsie Mae King					
	19a. Informant's Name/Relationship (Type, Print) Bonita M. Hanes / Daughter			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8824 Ridge Road, Bethesda, Maryland 20817						
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Prospect Hill Cemetery			Date April 21, 2007	20c. Location - City or Town, State York, Pennsylvania			
	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501							
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Pneumonia a. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dementia b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):								Approximate Interval Between Onset and Death	
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome pf pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown					23d. Date of delivery Month Day Year		
Medical Certification: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
									24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
									24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) Hospice							
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred			
			28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)					
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								29d. Date signed (Month, Day, Year) April 17, 2007	
	29b. Signature and title of certifier Cynthia M. Williams DO				29c. License number H0058032					
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Cynthia M. Williams, D.O. 6001 Muncaster Mill Road, Rockville, Maryland 20855									
State Registrar	31. Date filed (Month, Day, Year) APR 18 2007		32. Registrar's Signature 							

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2007 12365

Reg. No.

1- For
State
Registrar

Physician
/Medical
Examiner

Baltimore, Maryland 21215-0036

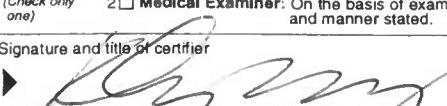
Permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or items 23a or 28a-1 show
any injury or other traumatic event, the Medical Examiner shall be notified at
once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760, 4th
To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial/transit

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year				3. Time of Death			
Edith Elizabeth Irwin		04-17-07				2:00 P M			
4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of Death				4c. County of Death			
Franklin Square Hospital Center		Rosedale				Baltimore			
5. Social Security Number		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 72 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days Hours Min.	8. Date of Birth (Month, Day, Year) 8/27/1934	9. Birthplace (State or Foreign Country) Maryland		
219-30-4409									
Usual Residence of Decedent									
10a. State Maryland	10b. County Baltimore	10c. City, Town or Location Middle River				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
10e. Street and Number 50 Transverse Avenue		10f. Zip Code 21220				10g. Citizen of What Country? U. S .A.			
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: White			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Typist	16b. Kind of Business/Industry Real Estate							
17. Father's Name (First, Middle, Last) George Smith		18. Mother's Name (First, Middle, Maiden Surname) Ruth Marse							
19a. Informant's Name/Relationship (Type, Print) Linda Wiseman (Daughter)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 50 Transverse Avenue Middle River, Maryland 21220							
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) 11		20b. Place of Disposition (Name of cemetery, crematory or other place) Parkwood Cemetery				Date 4/23/2007	20c. Location - City or Town, State Parkville, Maryland		
21. Signature of Funeral Service Licensee Michael C. Jaffee Sr.		22. Name and Address of Facility Brudzinski Funeral Home PA 1407 Old Eastern Avenue Essex, Maryland 21221							
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)								Approximate Interval Between Onset and Death months	
<p>a. <u>COPD Endstage</u> Due to (or as a consequence of):</p> <p>b. <u>Acute Renal Failure</u> Due to (or as a consequence of):</p> <p>c. _____ Due to (or as a consequence of):</p> <p>d. _____</p>									
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____ <input type="checkbox"/> Unknown				23d. Date of delivery Month Day Year			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Diabetes Mellitus</u>								23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				23f. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred			
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								29b. Signature and title of certifier 	
29c. License number 054736		29d. Date signed (Month, Day, Year) 04-17-07							
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Kamlin Auyeyung 9000 Franklin Square Drive Baltimore, MD 21237								31. Date filed (Month, Day, Year) APR 18 2007	
32. Registrar's Signature 									

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

1- For State Amend 4a, per MD, 6866, 4/19/07 TT
Registrar

State of Maryland / Department of Health and Mental Hygiene 2007 12366
Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Evelyn Amanda Johnson							2. Date of Death Month 04 Day 16 Year 2007	3. Time of Death 7:50 AM	
	4a. Facility Name (If not institution, give street and number) Joseph Richey Hospice			4b. City, Town, or Location of Death Baltimore			4c. County of Death N/A			
Funeral Director	5. Social Security Number 219-38-5901	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 64 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days Hours Min.	8. Date of Birth (Month, Day, Year) 06/16/1942	9. Birthplace (State or Foreign Country) MD			
To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State MD 10b. County N/A 10c. City, Town or Location Baltimore								10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
	10e. Street and Number 2107 Cliftwood Avenue				10f. Zip Code 21213			10g. Citizen of What Country? USA		
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: 11th grade			13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: Black			14. Race - American Indian, Black, White, etc. Specify: Black		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Nurses Assistant			16b. Kind of Business/Industry Stella			
	17. Father's Name (First, Middle, Last) Hiram Jordan				18. Mother's Name (First, Middle, Maiden Surname) Evelyn Neal					
	19a. Informant's Name/Relationship (Type, Print) Rhonda Swann/Daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5222 Saybrook Road Baltimore MD 21206					
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) Arbutus Memorial				20b. Place of Disposition (Name of cemetery, crematory or other place) Arbutus Memorial		Date 04/21/07	20c. Location - City or Town, State Baltimore MD		
	21. Signature of Funeral Service Licensee ► ETSO MD				22. Name and Address of Facility Vaughn C. Greene Funeral service 4905 York Road Baltimore MD 21212					
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) biliary cancer with carcinomatosis Due to (or as a consequence of): Weeks								Approximate Interval Between Onset and Death	
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last {									
	a. biliary cancer with carcinomatosis Due to (or as a consequence of): Weeks	b. Due to (or as a consequence of):	c. Due to (or as a consequence of):	d. Due to (or as a consequence of):						
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown <input type="checkbox"/> Other (specify) Hospice			23d. Date of delivery Month Day Year					
Medical Certification: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
									24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) Hospice	
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)								28f. Location (Street and Number or Rural Route Number, City or Town, State)	
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								29b. Signature and title of certifier ► ETSO MD	
	29c. License number D24170								29d. Date signed (Month, Day, Year) April 16, 2007	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) E.TSO MD Richey Hospice 838 N Eutaw St Baltimore, MD 21201								31. Date filed (Month, Day, Year) APR 18 2007	
State Registrar	32. Registrar's Signature ► ETSO MD								ORIGINAL	

Baltimore, Maryland 21215-0036

Evelyn Johnson 4/16/07
Division of Vital Records, P.O. Box 68760, MD

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit once.

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 12367

1- For State Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>Sydney Simone Maria Johnson</i>						2. Date of Death Month April Day 15 Year 2007			3. Time of Death 12:22 AM	
	4a. Facility Name (If not institution, give street and number) <i>University of Maryland Medical Center</i>			4b. City, Town, or Location of Death <i>Baltimore</i>			4c. County of Death <i>N/A</i>				
Funeral Director	5. Social Security Number <i>N/A</i>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <i>0 Yrs.</i>	If Under 1 Year <input type="checkbox"/> Months 0	If Under 24 Hrs. <input type="checkbox"/> Days 25	Hours <input type="checkbox"/>	Min. <input type="checkbox"/>	8. Date of Birth (Month, Day, Year) <i>03/21/2007</i>	9. Birthplace (State or Foreign Country) <i>MD</i>		
To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State <i>MD</i> 10b. County <i>N/A</i> 10c. City, Town or Location <i>Baltimore</i>						10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				
	10e. Street and Number <i>2049 E. Belvedere Avenue</i>			10f. Zip Code <i>21239</i>			10g. Citizen of What Country? <i>USA</i>				
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: <i>N/A</i>		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: <i>N/A</i>			14. Race - American Indian, Black, White, etc. Specify: <i>Black</i>			
	15. Decedent's Education (Specify only highest grade completed) <i>Elementary/Secondary (0-12) N/A</i>			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>N/A</i>			16b. Kind of Business/Industry <i>N/A</i>				
	17. Father's Name (First, Middle, Last) <i>Tauron Black</i>						18. Mother's Name (First, Middle, Maiden Surname) <i>Cerissa Johnson</i>				
	19a. Informant's Name/Relationship (Type, Print) <i>Ceresa Johnson</i>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>2049 E. Belvedere Avenue Baltimore MD 21239</i>			20c. Location - City or Town, State <i>Baltimore, MD</i>				
Physician /Medical Examiner	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <i>Greenmount Crematory</i>			20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Greenmount Crematory</i>			Date <i>04/23/07</i>				
	21. Signature of Funeral Service Licensee <i>Bn Clyn m01363</i>			22. Name and Address of Facility <i>Vaughn C. Greene Funeral Services 4905 York Road Baltimore MD 21212</i>							
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <i>Septic Shock</i> Due to (or as a consequence of): <i>Necrotizing Enterocolitis</i> Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <i>Extreme prematurity</i> Due to (or as a consequence of): d.										
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown			23c. If yes, outcome pf pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year				
Medical Certification: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown				
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide			28a. Date of Injury (Month, Day Year) <i>M</i> 28b. Time of Injury <i>M</i> 28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No			28d. Describe how injury occurred 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) <i>22 South Greene Street</i>				
	29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.			29c. License number <i>P18653</i>			29d. Date signed (Month, Day, Year) <i>April 15, 2007</i>				
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Benedict Asiegbu</i>						31. Date filed (Month, Day, Year) <i>APR 18 2007</i>				
State Registrar	32. Registrar's Signature <i>Asiegbu</i>										

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division or Vital Records, P.O. Box 68760, MD

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene
Certificate of Death

Reg. No. 2007 12368

1- For State Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) EDWARD JAMES JR				2. Date of Death Month 04 Day 15 Year 2007	3. Time of Death 7:05 PM					
	4a. Facility Name (If not institution, give street and number) BALTIMORE REHABILITATION EXTENDED CARE BALTIMORE		4b. City, Town, or Location of Death BALTIMORE		4c. County of Death Texas						
Funeral Director	5. Social Security Number 455-98-3794		6. Sex 1 X M 2 F	7. Age (In yrs. last birthday) 53 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) 09/06/1953	9. Birthplace (State or Foreign Country) Texas			
	Usual Residence of Decedent		10a. State Maryland		10b. County Baltimore		10c. City, Town or Location Baltimore		10d. Inside City Limits 1 X Yes 2 No		
To Be Completed by Funeral Director	10e. Street and Number 2039 Grinnalds Street				10f. Zip Code 21230		10g. Citizen of What Country? U.S.A.				
	11. Marital Status 1 □ Never Married 2 □ Married 3 X Widowed 4 □ Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No 1979 If Yes, Give Year of Dates: 1984		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 □ Yes 2 X No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black				
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Postal Clerk		16b. Kind of Business/Industry U.S. Post Office				
	17. Father's Name (First, Middle, Last) Edward James Sr.				18. Mother's Name (First, Middle, Maiden Surname) Faye Otley						
	19a. Informant's Name/Relationship (Type. Print) Eunice R. Lewis /Fiance				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2039 Grinnalds Street, Baltimore, Maryland 21230						
	20a. Method of Disposition 1 □ Burial 2 X Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Metro Crematory Inc.		Date 04/17/2007	20c. Location - City or Town, State Baltimore, Maryland				
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility The Derrick C. Jones F/H, P.A. 4611 Park Hgts. Ave., Baltimore, Maryland 21215						
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. VARICELLA ZOSTER MENINGITIS Due to (or as a consequence of): b. ACQUIRED IMMUNE DEFICIENCY SYNDROME Due to (or as a consequence of): c. _____ d. _____							Approximate Interval Between Onset and Death			
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify)				23d. Date of delivery Month Day Year				
Medical Certification: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CHRONIC RENAL FAILURE							23e. Did tobacco use contribute to the cause of death? 1 □ Yes 2 □ No 3 □ Probably 4 X Unknown			
	25. Was case referred to medical examiner? 1 □ Yes 2 X No		26. Place of Death (Check only one) Hospital: 1 □ Inpatient 2 □ ER/Outpatient 3 □ DOA Other: 4 X Nursing Home 5 □ Residence 6 □ Other (Specify)		23f. Was an autopsy performed? 1 □ Yes 2 X No					24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No	
	27. Manner of Death 1 X Natural 5 □ Pending investigation 2 □ Accident 6 □ Could not be determined 3 □ Suicide 4 □ Homicide		28a. Date of Injury (Month, Day Year) 28b. Time of Injury M		28c. Injury at Work? 1 □ Yes 2 □ No		28d. Describe how injury occurred				
			28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) At home		28f. Location (Street and Number or Rural Route Number, City or Town, State) Baltimore, Maryland						
	29a. Certifier (Check only one) 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 □ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29c. License number D24648		29d. Date signed (Month, Day, Year) 04-15-2007						
	29b. Signature and title of certifier Sher A Hashmi MD										
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SHER A HASHMI MD 3900 COCH RAVEN RD BALTIMORE MD 21218										
State Registrar	31. Date filed (Month, Day, Year) APR 18 2007		32. Registrar's Signature 		ORIGINAL						

Baltimore, Maryland 21215-0036
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural"; or items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.Division or Vital Records, P.O. Box 68760, ✓
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

6
State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 | 2369

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) John Foutz Joesting Jr.						2. Date of Death Month Day Year April 13 2007 552 PM			3. Time of Death
	4a. Facility Name (If not institution, give street and number) 894 Calvary Road			4b. City, Town, or Location of Death Churchville			4c. County of Death Harford			
Funeral Director	5. Social Security Number 213-42-2937	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 64 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) Dec. 17, 1942	9. Birthplace (State or Foreign Country) Maryland			
	Usual Residence of Decedent 10a. State Maryland			10b. County Harford			10c. City, Town or Location Churchville			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
10e. Street and Number 894 Calvary Road				10f. Zip Code 21028			10g. Citizen of What Country? USA			
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: 1945-1948			13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: White			14. Race - American Indian, Black, White, etc. Specify:		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Welder			16b. Kind of Business/Industry Construction			
17. Father's Name (First, Middle, Last) John Foutz Joesting Sr.				18. Mother's Name (First, Middle, Maiden Surname) Mary Emmert Kaylor						
19a. Informant's Name/Relationship (Type, Print) Jonie Joesting Alcorn / Daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 320 Ella St., Smyrna, TN 37167			19c. Date			
20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) Bel Air Memorial Grdn				20b. Place of Disposition (Name of cemetery, crematory or other place) 4-17-07			20c. Location - City or Town, State Bel Air, Maryland			
21. Signature of Funeral Service Licensee Charles A. Engle				22. Name and Address of Facility McComas Funeral Home, P.A. 50 W. Broadway, Bel Air, Maryland 21014						
23a. Part I. Enter the disease, or complication(s) that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Arteriosclerotic Cardiovascular disease							Approximate Interval Between Onset and Death			
a. Due to (or as a consequence of): Arteriosclerotic Cardiovascular disease										
b. Due to (or as a consequence of): 										
c. Due to (or as a consequence of): 										
d. Due to (or as a consequence of): 										
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input checked="" type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown			3. Ectopic pregnancy <input type="checkbox"/> Other (Specify)			23d. Date of delivery Month Day Year		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Diabetes COPD Cancer of Bladder				23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown						
				24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA			Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			26. Place of Death Check only one M 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)			28b. Time of Injury			28c. Injury at Work? M 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
								28d. Describe how injury occurred		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) At home								28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					29c. License number MD 1044206			29d. Date signed (Month, Day, Year) April 13 2007		
29b. Signature and title of certifier Bernard J. Yekutia MD, DME										
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BERNARD J. YEKUTIA MD, DME 1614 CHURCHVILLE RD. BEL AIR MD 21015										
31. Date filed (Month, Day, Year) APR 18 2007		32. Registrar's Signature Leanne B. Spangler								

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or if items 23e or 28e-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

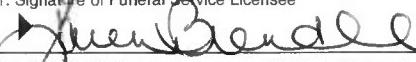
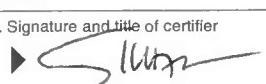
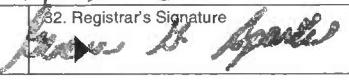
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2007 12370

Reg. No.

1- For State Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) DON E KEEBLE							2. Date of Death Month Day Year April 12, 2007	3. Time of Death 6:35 A M
	4a. Facility Name (If not institution, give street and number) Frederick Memorial Hospital			4b. City, Town, or Location of Death Frederick			4c. County of Death Frederick		
Funeral Director	5. Social Security Number 408-74-9868		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 63 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) Dec 17, 1943	9. Birthplace (State or Foreign Country) Knoxville, TN	
To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State MD 10b. County Frederick 10c. City, Town or Location Frederick								10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
	10e. Street and Number 5054 Croydon Terrace				10f. Zip Code 21703			10g. Citizen of What Country? USA	
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 1		Circulation Manager			16b. Kind of Business/Industry Newspaper	
	17. Father's Name (First, Middle, Last) Harold Keeble				18. Mother's Name (First, Middle, Maiden Surname) Opal Littleton				
	19a. Informant's Name/Relationship (Type, Print) Joan Keeble - Wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5054 Croydon Terrace Frederick, MD 21703				
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Grandview Cemetery		Date 4-15-07	20c. Location - City or Town, State Maryville, TN			
	21. Signature of Funeral Service Licensee 								
	22. Name and Address of Facility McCammon-Ammons-Click Funeral Home 220 West Broadway Maryville, TN 37801								
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) BASAL CELL CANCER - DORSUM.								Approximate Interval Between Onset and Death
	23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown								
	23c. If yes, outcome pf pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown								
	23d. Date of delivery Month Day Year								
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown
	23f. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	23g. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								26. Place of Death (Check only one) <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide								28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 28d. Describe how injury occurred
	28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)								28f. Location (Street and Number or Rural Route Number, City or Town, State)
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
	29b. Signature and title of certifier 								29c. License number D 47951
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SIBTE A. KAZMI, MD 814 TOLL HOUSE AVE FREDERICK, MD 21701								29d. Date signed (Month, Day, Year) 4-13-2007
State Registrar	31. Date filed (Month, Day, Year) APR 18 2007				32. Registrar's Signature 				

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

10

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2007 12371

1 - For
State
Registrar

Physician
/Medical
Examiner

Funeral
Director

Important: If item 27 is marked other than "natural", or items 23a or 28c-f show any injury or other traumatic event, the Medical Examiner must be notified once.

To Be Completed by Funeral Director

1. Decedent's Name (First, Middle, Last)	Wayne Edward Kirker				2. Date of Death Month Day Year	3. Time of Death 7:30P M			
4a. Facility Name (If not institution, give street and number) Saint Joseph Medical Center			4b. City, Town, or Location of Death Towson			4c. County of Death Baltimore			
5. Social Security Number 191-18-3818	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 82 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	Hours	Min.			
8. Date of Birth (Month, Day, Year) AUG 8, 1924							9. Birthplace (State or Foreign Country) Pennsylvania		
10a. State Maryland							10b. County Carroll	10c. City, Town or Location Sykesville	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No X
10e. Street and Number 1620 Andylin Way			10f. Zip Code 21784			10g. Citizen of What Country? USA			
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: WWII			13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: White			14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 5+			16b. Kind of Business/Industry Therapist/Teacher Physical Therapy			
17. Father's Name (First, Middle, Last) Walter E. Kirker					18. Mother's Name (First, Middle, Maiden Surname) Edna Lowers				
19a. Informant's Name/Relationship (Type, Print) Eva M. Kirker			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1620 Andylin Way Sykesville, MD 21784						

20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)	20b. Place of Disposition (Name of cemetery, crematory or other place) All County Cremation Service	Date 4/18/2007	20c. Location - City or Town, State Sykesville, MD
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21. Signature of Funeral Service Licensee ► David McDonald	22. Name and Address of Facility Haight Funeral Home & Chapel, P.A. P.O. Box 195 Sykesville, MD 21784 (410-795-1400)
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23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)	Approximate Interval Between Onset and Death 48 HOURS
a. Due to (or as a consequence of): ACUTE MYOCARDIAL INFARCTION	72 HOURS
b. Due to (or as a consequence of):	
c. Due to (or as a consequence of):	
d. Due to (or as a consequence of):	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown <input type="checkbox"/> Other (specify) _____	23d. Date of delivery Month Day Year
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Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown
				24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No

25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred	
28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)		

29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
--

29b. Signature and title of certifier ► Imran Siddiqi	29c. License number D0063974	29d. Date signed (Month, Day, Year) 4/17/07
--	---------------------------------	--

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) IMRAN SIDDIQI M.D. 7601 OSLER DRIVE TOWSON, MARYLAND 21204
--

31. Date filed (Month, Day, Year) APR 18 2007	32. Registrar's Signature Leanne B. Spotts
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Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2007 12372

Reg. No.

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>Elizabeth Krutko</i>				2. Date of Death Month April Day 16th Year Year 2007	3. Time of Death 10:40 AM		
	4a. Facility Name (If not institution, give street and number) <i>Howard County Genal Hosp</i>		4b. City, Town, or Location of Death <i>Columbia</i>		4c. County of Death <i>Howard</i>			
Funeral Director	5. Social Security Number <i>194 01 7901</i>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <i>97 Yrs.</i>	If Under 1 Year Months	If Under 24 Hrs. Days Hours Min.	8. Date of Birth (Month, Day, Year) <i>AUG 1, 1909</i>	9. Birthplace (State or Foreign Country) <i>PA</i>	
	10a. State <i>MD</i> 10b. County <i>Howard</i> 10c. City, Town or Location <i>Ellicott City</i>				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <i>XX</i>			
To Be Completed by Funeral Director	10e. Street and Number <i>2817 MONTCLAIR DR.</i>			10f. Zip Code <i>21042</i>	10g. Citizen of What Country? <i>USA</i>			
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: <i>xx</i>	13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: <i>WHITE</i>	14. Race - American Indian, Black, White, etc. Specify:		
	15. Decedent's Education (Specify only highest grade completed) <i>Elementary/Secondary (0-12) 3</i>			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>HOMEMAKER</i>	16b. Kind of Business/Industry <i>DOMESTIC</i>			
	17. Father's Name (First, Middle, Last) <i>JOHN BINO</i>			18. Mother's Name (First, Middle, Maiden Surname) <i>MARY</i>				
Physician /Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <i>LAWRENCE L. KRUTKO</i>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>1565 SIXTH ST. WAYNESBURG, PA 15370</i>			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input checked="" type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <i>K. GREGORY FINK</i>		20b. Place of Disposition (Name of cemetery, crematory or other place) <i>GREENE CO. MEMORIAL PARK</i>		Date <i>4.20.2007</i>	20c. Location - City or Town, State <i>WAYNESBURG, PA</i>		
Medical Certification: To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee <i>K. GREGORY FINK</i>				22. Name and Address of Facility <i>FTNK FUNERAL HOME, P.A. t/a MARYLAND MORTUARY SUPPORT 426 CRAIN HNY S GLEN BURNIE, MD 21061</i>			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <i>Congestive heart failure</i>				Approximate Interval Between Onset and Death			
	<p>a. Due to (or as a consequence of): <i>Pneumonia</i></p> <p>b. Due to (or as a consequence of): <i>Hypoxia</i></p> <p>c. Due to (or as a consequence of): <i>Coronary artery disease</i></p>							
	23b. If female: 23c. If yes, outcome pf pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown				23d. Date of delivery Month Day Year			
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Hypercholesterolemia</i>				23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown			
	25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred	
	28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) <i>At home</i>		28f. Location (Street and Number or Rural Route Number, City or Town, State) <i>5005 Signal Bell Lane Clarksville MD 21029</i>					
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29c. License number <i>D50870</i>			
	29b. Signature and title of certifier <i>Susan Asolo</i>				29d. Date signed (Month, Day, Year) <i>April 16th 2007</i>			
31. Date filed (Month, Day, Year) <i>APR 18 2007</i>		32. Registrar's Signature <i>Jeanne A. Johnson</i>						

Baltimore, Maryland 21215-0036

Permit: Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or items 2a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division or Vital Records, P.O. Box 68760, 4

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State
Registrar

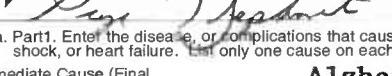
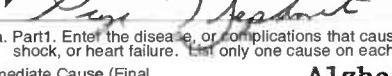
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

.2007 12373

Physician /Medical Examiner		1. Decedent's Name (First, Middle, Last) Marie Esther Kane							2. Date of Death Month Day Year April 14, 2007		3. Time of Death 7:55 AM M	
		4a. Facility Name (If not institution, give street and number) 4400 East West Highway #408				4b. City, Town, or Location of Death Bethesda				4c. County of Death Montgomery		
Funeral Director		5. Social Security Number 076-10-9916		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 90 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) December 26, 1916	9. Birthplace (State or Foreign Country) New York			
		Usual Residence of Decedent Maryland		10a. State Maryland		10b. County Montgomery		10c. City, Town or Location Bethesda		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
To Be Completed by Funeral Director		10e. Street and Number 4400 East West Highway #408				10f. Zip Code 20814			10g. Citizen of What Country? United States			
		11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced				12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: Elementary/Secondary (0-12) College (1-4 or 5+) 4			13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 4			
To Be Completed by Physician/Medical Examiner		17. Father's Name (First, Middle, Last) John O'Malley				18. Mother's Name (First, Middle, Maiden Surname) Dorothy Oulehan			14. Race - American Indian, Black, White, etc. Specify: White			
		19a. Informant's Name/Relationship (Type, Print) Esther Kane / Daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4400 East West Highway #408 Bethesda, Maryland 20814			16b. Kind of Business/Industry United States Government			
Physician /Medical Examiner		20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  M00335				20b. Place of Disposition (Name of cemetery, crematory or other place) Montgomery Crematorium Inc.			Date April 16, 2007	20c. Location - City or Town, State Bethesda, Maryland		
		21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue Bethesda, Maryland 20814-3501						
Division or Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Alzheimer's Dementia							Approximate Interval Between Onset and Death Years			
		{ a. Due to (or as a consequence of): Atrial Fibrillation b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):							Years			
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit		23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown				23c. If yes, outcome pf pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year			
						3 <input type="checkbox"/> Ectopic pregnancy 5 <input type="checkbox"/> Other (specify)						
Medical Certification: To Be Completed by Physician/Medical Examiner		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Colon Cancer							23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit		25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred				
						28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit		29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit		29b. Signature and title of certifier 				29c. License number D47215			29d. Date signed (Month, Day, Year) April 16, 2007			
State Registrar		31. Date filed (Month, Day, Year) APR 18 2007		32. Registrar's Signature 								

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed

Within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director name 2 should be detached for use as the burial trans-

Baltimore: Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**State
registrar**

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
amend Item 19a per In good 4-20-07 vt

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2007 12374

For
State
Registrar

Physician
/Medical
Examiner

Funeral
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

Theresa Keene 4/12/07 7:30am
Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 23b-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

1. Decedent's Name (First, Middle, Last)	Theresa Olivia Keene				2. Date of Death Month Day Year 4 12 2007	3. Time of Death 7:30 a.m.			
4a. Facility Name (If not institution, give street and number) 2308 Round Road			4b. City, Town, or Location of Death Baltimore		4c. County of Death NA				
5. Social Security Number 220-54-7044		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 57 Yrs.	If Under 1 Year Months Days Hours Min.	8. Date of Birth (Month, Day, Year) 8 31 1949	9. Birthplace (State or Foreign Country) MD			
10a. State MD		10b. County NA		10c. City, Town or Location Baltimore			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
10e. Street and Number 2308 Round Road			10f. Zip Code 21225			10g. Citizen of What Country? U S A			
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10th grade		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) NA		16b. Kind of Business/Industry Nurse Assistant			NA		
17. Father's Name (First, Middle, Last) William Alonzo Spence				18. Mother's Name (First, Middle, Maiden Surname) Elnora Skinner					
19a. Informant Name/Relationship (Type, Print) Doreen Martin - Daughter			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 562 5th Avenue Halethorpe, MD 21227			Date 4-19-2007			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Cedar Hill Cem		20c. Location - City or Town, State Anne Arundel Co, MD					
21. Signature of Funeral Service Licensee ► Gladys Ware		22. Name and Address of Facility March F/H East 1101 E. North Avenue Balto, MD 21202							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Lung cancer Due to (or as a consequence of):								Approximate Interval Between Onset and Death months	
b. Due to (or as a consequence of):									
c. Due to (or as a consequence of):									
d. Due to (or as a consequence of):									
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fatal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes <input type="checkbox"/> No	
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	28c. Injury at Work? 1 <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
29b. Signature and title of certifier ► ETSO MD		29c. License number D24170		29d. Date signed (Month, Day, Year) April 13, 2007					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ETSO MD Richey Hospice 838 N. Entwistle St. Baltimore MD 21201									
31. Date filed (Month, Day, Year) APR 18 2007		32. Registrar's Signature Audrey B. Spotts							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 12375

1- For State Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) MAGGIE MARGARET LUCAS							2. Date of Death Month April Day 7 Year 2007			3. Time of Death 6:32 P M
	4a. Facility Name (If not institution, give street and number) Sinai Hospital of Baltimore			4b. City, Town, or Location of Death Baltimore City			4c. County of Death N/A				
Funeral Director	5. Social Security Number 228-10-4619	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 90 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Hours	8. Date of Birth (Month, Day, Year) FEB 12 1917	9. Birthplace (State or Foreign Country) VIRGINIA				
	Usual Residence of Decedent 10a. State MARYLAND 10b. County N/A			10c. City, Town or Location BALTIMORE			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				
To Be Completed by Funeral Director	10e. Street and Number 2218 PRESSTMAN STREET				10f. Zip Code 21216		10g. Citizen of What Country? U.S.A.				
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: XX			13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: BLACK			14. Race - American Indian, Black, White, etc. Specify: BLACK			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th grade			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) COOK			16b. Kind of Business/Industry DOMESTIC				
	17. Father's Name (First, Middle, Last) RONNIE MATHEWS				18. Mother's Name (First, Middle, Maiden Surname) MARGUERITE JACKSON						
	19a. Informant's Name/Relationship (Type, Print) Shanae Woodberry/Granddaughter			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2218 Presstman St., Baltimore, Maryland 21216							
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) METRO CREMATORIAL			20b. Place of Disposition (Name of cemetery, crematory or other place) METRO CREMATORIAL			Date 04-18-07	20c. Location - City or Town, State BALTIMORE, MARYLAND			
	21. Signature of Funeral Service Licensee Parthena C Brown			22. Name and Address of Facility WILLIAM C BROWN COMMUNITY FUNERAL HOME P.A. 1206 W NORTH AVENUE							
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last									Approximate Interval Between Onset and Death	
	<p>a. Myocardial Infarction Due to (or as a consequence of):</p> <p>b. Severe Pulmonary Hypotension Due to (or as a consequence of):</p> <p>c. Mitral Regurgitation Due to (or as a consequence of):</p> <p>d.</p>										
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown			23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year				
Medical Certification: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Hyponatremia Colon mass							23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
	25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DCA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			23f. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide			28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred				
				28e. Place of Injury At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)				
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
	29b. Signature and title of certifier Samarra Ahmad, MD			29c. License number D63198			29d. Date signed (Month, Day, Year) April 7, 2007				
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Samarra Ahmad, MD, Sinai Hospital of Baltimore										
State Registrar	31. Date filed (Month, Day, Year) APR 18 2007			32. Registrar's Signature Parthena C Brown							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2007 12376

Reg. No.

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Frances Mae Lewis							2. Date of Death Month Day Year April 13, 2007	3. Time of Death 11:35 PM
	4a. Facility Name (If not institution, give street and number) Prince George's Hospital			4b. City, Town, or Location of Death Cheverly			4c. County of Death Prince George's		
Funeral Director	5. Social Security Number 578-48-6254	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 70 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	Hours	Min.	8. Date of Birth (Month, Day, Year) May 7, 1936	9. Birthplace (State or Foreign Country) Virginia
To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State DC 10b. County none 10c. City, Town or Location Washington, DC								10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
	10e. Street and Number 4075 Minnesota Avenue NE				10f. Zip Code 20019			10g. Citizen of What Country? USA	
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: 1945			13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: Black			14. Race - American Indian, Black, White, etc.	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Domestic Work			16b. Kind of Business/Industry Domestic		
	17. Father's Name (First, Middle, Last) (Unknown)				18. Mother's Name (First, Middle, Maiden Surname) Elizabeth Lewis				
	19a. Informant's Name/Relationship (Type, Print) Darlyn Johnson - Daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1109 60th Avenue Fairmont Heights, MD 20743				
Physician /Medical Examiner	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) Family Cemetery			20b. Place of Disposition (Name of cemetery, crematory or other place) Family Cemetery		Date 4-20-07	20c. Location - City or Town, State Orange Co., VA		
	21. Signature of Funeral Service Licensee Debra Blende				22. Name and Address of Facility Bailey Funeral Service 1207 White St. Fredericksburg, VA 22401				
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) FATAL CARDIAC ARRHYTHMIA								Approximate Interval Between Onset and Death
	Sequential list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last LUNG CANCER								
	c. Due to (or as a consequence of): ASTHMA								
	d.								
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year			
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								
	23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown								
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide				28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred	
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				
	29b. Signature and title of certifier DR GARY LITTLE				29c. License number D58951			29d. Date signed (Month, Day, Year) 4-16-01	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR GARY LITTLE				31. Date filed (Month, Day, Year) APR 18 2007				
	32. Registrar's Signature Jessica B. Spangler								

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit slip.

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner will be notified at once.

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 12377

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Murray Latish							2. Date of Death Month Day Year April 11, 2007	3. Time of Death 15:26 M		
	4a. Facility Name (If not institution, give street and number) Shady Grove Adventist Hospital			4b. City, Town, or Location of Death Rockville			4c. County of Death Montgomery				
Funeral Director	5. Social Security Number 050-01-7733		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) 92 Yrs.	If Under 1 Year Months Days Hours Min.	8. Date of Birth (Month, Day, Year) Oct 13, 1914	9. Birthplace (State or Foreign Country) NY				
	Usual Residence of Decedent MD		10a. State MD			10b. County Montgomery			10c. City, Town or Location Silver Spring	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No XX	
To Be Completed by Funeral Director	10e. Street and Number 14508 Home Crest Dr. APT 223				10f. Zip Code 20906-1802			10g. Citizen of What Country? USA			
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: 1945-1946		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc. 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Machinist		16b. Kind of Business/Industry Airplane						
	17. Father's Name (First, Middle, Last) Unk				18. Mother's Name (First, Middle, Maiden Surname) Ann						
	19a. Informant's Name/Relationship (Type, Print) Andrea Latish Daughter in Law				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4501 Daley Manor Pl, Olney, MD 20832						
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Baron Hirsch Cemetery		Date	20c. Location - City or Town, State April 17, 2007 Staten Island, NY					
	21. Signature of Funeral Service Licensee K. Gregory Fink M01148		22. Name and Address of Facility Fink Funeral Home, P.A. 426 Crain Hwy S, Glen Burnie, MD 21061								
Physician /Medical Examiner	23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) myocardial infarction										Approximate Interval Between Onset and Death minutes
	<p>a. Due to (or as a consequence of):</p> <p>b. Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. Due to (or as a consequence of):</p>										
Medical Certification: To Be Completed by Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome pf pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year						
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown						
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death Check only one Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		23f. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No						
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred						
	28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)								
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29c. License number 0-2018		29d. Date signed (Month, Day, Year) April 11 2007						
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Steven Dolinsky 911 Russell Ave Gaithersburg Md.										
State Registrar	31. Date filed (Month, Day, Year) APR 18 2007		32. Registrar's Signature Suzanne B. Gaskins		ORIGINAL						

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM #9, per FH, G866, 4/18/07, WS

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 12378

1- For
State
RegistrarPhysician
/Medical
ExaminerFuneral
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
 Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State
Registrar

		1. Decedent's Name (First, Middle, Last) <i>Bruce Line</i>				2. Date of Death Month 4 Day 17 Year 2007		3. Time of Death 805A M	
		4a. Facility Name (If not institution, give street and number) 7 Deep Run Ct.				4b. City, Town, or Location of Death Cockeysville		4c. County of Death Baltimore	
		5. Social Security Number 172-38-0465	6. Sex M	7. Age (In yrs. last birthday) 59 Yrs.	If Under 1 Year Months 0 Days 0	If Under 24 Hrs. Hours 0 Min. 0	8. Date of Birth (Month, Day, Year) 10/21/1947	9. Birthplace (State or Foreign Country) PA MD	
		10a. State MD		10b. County Baltimore		10c. City, Town or Location Cockeysville		10d. Inside City Limits 1 Yes 2 No	
		10e. Street and Number 7 Deep Run Ct.				10f. Zip Code 21030		10g. Citizen of What Country? United States	
		11. Marital Status 1 Never Married 2 Married		12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: 81-07		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No Specify:		14. Race - American Indian, Black, White, etc. White	
		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (O-12)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Physician		16b. Kind of Business/Industry University of Maryland			
		17. Father's Name (First, Middle, Last) Lemuel Line				18. Mother's Name (First, Middle, Maiden Surname) Marion Clowes			
		19a. Informant's Name/Relationship (Type, Print) Beth Line/Wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7 Deep Run Ct. Cockeysville, MD 21030			
		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State				20b. Place of Disposition (Name of cemetery, crematory or other place) Chesapeake Crematory Inc. 2007		20c. Location - City or Town, State Apr 18 Beltsville, Maryland	
		21. Signature of Funeral Service Licensee <i>Syndra Line-Beth M01443</i>				22. Name and Address of Facility Cremation and Funeral Alternatives 8717 Green Pastures Drive Baltimore, Maryland 21204			
		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Metastatic Colon Cancer				23b. Proximate Interval Between Onset and Death 6/05			
		<p>a. Due to (or as a consequence of): <i>Metastatic Colon Cancer</i></p> <p>b. Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. Due to (or as a consequence of):</p>							
		23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown				23d. Date of delivery Month 0 Day 0 Year 0			
		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown			
						24a. Was an autopsy performed? 1 Yes 2 No			
						24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No			
		25. Was case referred to medical examiner? 1 Yes 2 No				26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)			
		27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide				28a. Date of Injury (Month, Day Year) M		28b. Time of Injury 1 Yes 2 No	
		28c. Injury at Work? 1 Yes 2 No				28d. Describe how injury occurred			
		28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) At home				28f. Location (Street and Number or Rural Route Number, City or Town, State) Univ. of Maryland College Park, 225 Greene St, Baltimore MD 21201			
		29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29c. License number D36146			
		29b. Signature and title of certifier <i>Kathleen Rall Travinkle</i>				29d. Date signed (Month, Day, Year) 4/17/2007			
		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Univ. of Maryland College Park, 225 Greene St, Baltimore MD 21201							
		31. Date filed (Month, Day, Year) APR 18 2007		32. Registrar's Signature <i>Jeanne L. Spangler</i>					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 12379

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) EDWARD E. LARKER						2. Date of Death Month MARCH Day 7, Year 2007	3. Time of Death 1800 M		
	4a. Facility Name (If not institution, give street and number) SHADY GROVE ADVENTIST HOSPITAL			4b. City, Town, or Location of Death ROCKVILLE			4c. County of Death Montgomery			
Funeral Director	5. Social Security Number 578-88-7482	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 38 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) May 27, 1968	9. Birthplace (State or Foreign Country) Wash., DC			
To Be Completed by Funeral Director	10a. State D.C. 10b. County						10c. City, Town or Location Washington			
	10e. Street and Number 4209 4th St., S.E. #9			10f. Zip Code 20032			10g. Citizen of What Country? United States			
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: Black			14. Race - American Indian, Black, White, etc. Specify: Black		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10th			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Laborer			16b. Kind of Business/Industry Private			
	17. Father's Name (First, Middle, Last) Melvin Larker, Sr.				18. Mother's Name (First, Middle, Maiden Surname) Sallie Jackson					
Physician /Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Rose M. Larker/Sister			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14913 Lear Lane Silver Spring, Md. 20905						
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) Mt. Zion Cemetery			20b. Place of Disposition (Name of cemetery, crematory or other place) Mt. Zion Cemetery			Date 4-2-07	20c. Location - City or Town, State Baltimore, Md.		
	21. Signature of Funeral Service Licensee Alvin Johnson, Jr.			22. Name and Address of Facility Capitol Mortuary, Inc. 1425 Maryland Ave., NE Wash., DC 20002						
	23a. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, stroke, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) MASSIVE PULMONARY EMBOLISM								Approximate Interval Between Onset and Death MINUTES	
	a. Due to (or as a consequence of): MASSIVE PULMONARY EMBOLISM									
	b. Due to (or as a consequence of):									
	c. Due to (or as a consequence of):									
	d. Due to (or as a consequence of):									
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown			23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown <input type="checkbox"/> Other (specify) Unknown			23d. Date of delivery Month Day Year			
Medical Certification: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ENDSTAGE HIV/AIDS								23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
	HIV CARDIOMYOPATHY WITH EF 20%								24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)	
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide			28a. Date of Injury (Month, Day, Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred			
	28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)								28f. Location (Street and Number or Rural Route Number, City or Town, State)	
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								29d. Date signed (Month, Day, Year) March 20, 2007	
	29b. Signature and title of certifier Dasgupta Arifit, M.D.								29c. License number D0064444	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dasgupta Arifit, M.D. 9901 Medical Center Dr. Rockville, Md. 20850									
State Registrar	31. Date filed (Month, Day, Year) APR 18 2007			32. Registrar's Signature [Signature]						

Division or Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a/b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Larker, Edward
Baltimore, Maryland 21215-0036

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

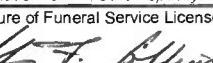
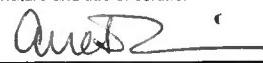
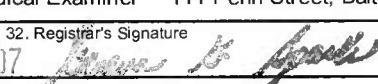
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2007 12380

1- For State
Registrar

Physician/ Medical Examiner	1. Decedent's Name (First, Middle, Last) Genevieve A. Leahy						2. Date of Death Month April Day 12, Year 2007	3. Time of Death 1730 hrs	
	4a. Facility Name (if not institution, give street and number) 2913 Louisiana Avenue			4b. City, Town, or Location of Death Lansdowne			4c. County of Death Baltimore County		
Funeral Director	5. Social Security Number 212-18-8754	6. Sex 1 M 2 F	7. Age (In yrs. last birthday) 85 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (MM/DD/YYYY) 06/24/1921	9. Birthplace (State or Foreign Country) Maryland		
	Usual Residence of Decedent 10a. State Maryland			10b. County Baltimore			10c. City, Town or Location Lansdowne		
10e. Street and Number 2913 Louisiana Avenue				10f. Zip Code 21227			10g. Citizen of What Country? U.S.A.		
To Be Completed by Funeral Director	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: N/A		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: White		14. Race - American Indian, Black, White, etc. White		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) N/A		16b. Kind of Business/Industry Homemaker		Own Home		
17. Father's Name (First, Middle, Last) James Patrick Kelly				18. Mother's Name (First, Middle, Maiden Surname) Ella Whalen					
19a. Informant's Name/Relationship (Type, Print) Lavelle D. Seifert (Daughter)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 140 Sandy Beach Drive Pasadena, Maryland 21122					
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other Specify: N/A		20b. Place of Disposition (Name of cemetery, crematory or other place) Crownsville V.A. Cem.		Date 04/16/07	20c. Location - City or Town, State Crownsville Maryland				
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility McCullly-Polyniak Funeral Home, P.A. 3204 Mountain Road Pasadena, Maryland 21122					
Physician/ Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							Approximate Interval Between Onset and Death	
	<p>Immediate Cause (Final disease or condition resulting in death) a. Multiple Injuries Due to (or as a consequence of):</p> <p>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (disease or injury that initiated events resulting in death) Last</p> <p>b. Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. Due to (or as a consequence of):</p>								
<input type="checkbox"/> UNPENDED <input type="checkbox"/> AMENDED									
IF FEMALE:		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown					23d. Date of delivery Month Day Year		
23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown									
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
								24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> N	24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other: Scene							
27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input checked="" type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year) FOUND: Apr 12, 2007		28b. Time of Injury 1210 hrs	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	28d. Describe how injury occurred Subject fell			
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Single Family		28f. Location (Street and Number or Rural Route Number, City or Town, State) 2913 Louisiana Avenue, Lansdowne, MD					
29a. Certifier 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
29b. Signature and title of certifier 		29c. License number O.C.M.E.			29d. Date signed (Month, Day, Year) April 13, 2007				
30. Name and address of person who completed cause of death (Item 23a) Ana Rubio MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201									
31. Date filed (Month, Day, Year) APR 18 2007		32. Registrar's Signature 							

Division of Vital Records, P.O. Box 68760, Baltimore, MD 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene
Certificate of Death

1- For State Registrar

2007 12381
Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last)							2. Date of Death		3. Time of Death			
	Bernice Lucas							Month	Day	Year	1124PM		
Funeral Director	4a. Facility Name (If not institution, give street and number)				4b. City, Town, or Location of Death			4c. County of Death					
	Northwest Hospital Center				Randallstown			Baltimore					
5. Social Security Number		6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year		If Under 24 Hrs.		8. Date of Birth		9. Birthplace (State or Foreign Country)			
219-26-8367		1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	68 Yrs.	Months	Days	Hours	Min.	Jan. 17, 1939	Year	Virginia			
Usual Residence of Decedent													
10a. State	10b. County	10c. City, Town or Location								10d. Inside City Limits			
Md.	N/A	Baltimore								1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No			
10e. Street and Number		Apt.		10f. Zip Code		10g. Citizen of What Country?							
11 Cobblestone Ct. #1				21208		USA							
11. Marital Status			12. Was Decedent Ever in U.S. Armed Forces?			13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)			14. Race - American Indian, Black, White, etc.				
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:			1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			Specify: Black				
15. Decedent's Education (Specify only highest grade completed)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)				16b. Kind of Business/Industry					
Elementary/Secondary (0-12) 12				College (1-4 or 5+) 0				Homemaker Own Home					
17. Father's Name (First, Middle, Last)						18. Mother's Name (First, Middle, Maiden Surname)							
Mitchell Nutt						Alice E. Hall							
19a. Informant's Name/Relationship (Type, Print)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)									
(Sister) Mrs. Virginia Harrod				6823 Fairlawn Ave. Balt. Md. 21215									
20a. Method of Disposition				20b. Place of Disposition (Name of cemetery, crematory or other place)				Date	20c. Location - City or Town, State				
1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				Metro Crematory				4/17/2007	Balt. Md.				
21. Signature of Funeral Service Licensee													
► Joseph L. Russ Joseph L. Russ Funeral Home, P.A. 2222 W. North Ave. Balt. Md. 21216													
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.													
Immediate Cause (Final disease or condition resulting in death)													
a. Due to (or as a consequence of): Atherosclerotic cardiovascular disease													
b. Due to (or as a consequence of):													
c. Due to (or as a consequence of):													
d. Due to (or as a consequence of):													
Approximate Interval Between Onset and Death													
23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown				23c. If yes, outcome pf pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown				23d. Date of delivery Month Day Year					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.													
23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown													
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No									
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one)									
				Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input checked="" type="checkbox"/> Home Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)									
27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day Year)		28b. Time of Injury		28c. Injury at Work? M 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred			
28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)									
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29c. License number									
				29d. Date signed (Month, Day, Year)									
29b. Signature and title of certifier ► Erica Tobin Muldowny, MD				29c. License number D0052760									
				29d. Date signed April 9 2007									
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)				31. Date filed (Month, Day, Year)									
5401 Old Court Road Randallstown, Maryland 21133				APR 18 2007									
32. Registrar's Signature				Erica Tobin Muldowny, MD									

Baltimore, Maryland 21215-0036

Permit, Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2007 12382

1- For State Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Nelleta Elaine Markwood						2. Date of Death Month April Day 15 Year 2007	3. Time of Death 2:59 P M	
	4a. Facility Name (If not institution, give street and number) SINAI HOSPITAL OF BALTIMORE			4b. City, Town, or Location of Death BALTIMORE CITY			4c. County of Death		
Funeral Director	5. Social Security Number 578-48-0450	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 78 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Hours	8. Date of Birth (Month, Day, Year) Oct. 3, 1928	9. Birthplace (State or Foreign Country) West Virginia		
	Usual Residence of Decedent MD Baltimore			10c. City, Town or Location Arbutus			10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
To Be Completed by Funeral Director	10e. Street and Number 1115 Elm Road			10f. Zip Code 21227			10g. Citizen of What Country? USA		
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: White			14. Race - American Indian, Black, White, etc. Specify: White		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 2 Homemaker		16b. Kind of Business/Industry Own Home				
	17. Father's Name (First, Middle, Last) Eston Reel			18. Mother's Name (First, Middle, Maiden Surname) Lena Riggleman					
	19a. Informant's Name/Relationship (Type, Print) Robert Gregory Markwood (Son)			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1309 Stevens Ave. Arbutus, MD 21227					
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Lahmansville Cemetery			Date 4-19-07	20c. Location - City or Town, State Lahmansville, WV	
Physician /Medical Examiner	21. Signature of Funeral Service Licensee 			22. Name and Address of Facility Schaeffer Funeral Home 11 N. Main St. Petersburg, WV 26847					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Pneumonia								Approximate Interval Between Onset and Death
	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Urosepsis								
	a. Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):								
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown			23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Cerebrovascular accident								23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
								23f. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
								24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)	
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined								28a. Date of Injury (Month, Day, Year) M 28b. Time of Injury M 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 28d. Describe how injury occurred	
28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)								28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								29b. Signature and title of certifier  DO	
29c. License number RES-000								29d. Date signed (Month, Day, Year) April 15, 2007	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KATJA KISELKJAK VASSILIADES, DO SINAI HOSPITAL OF BALTIMORE								31. Date filed (Month, Day, Year) APR 18 2007	
32. Registrar's Signature 								33. Registrar's Signature Leanne L. Appling	

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit slip.

Important: If item 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

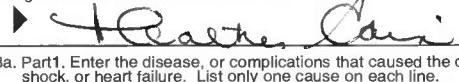
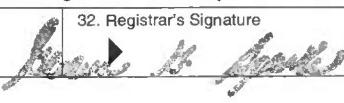
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 12383

1- For State Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Doris Jean Marr					2. Date of Death Month Day Year April 14, 2007	3. Time of Death 10:00 a.m.			
	4a. Facility Name (If not institution, give street and number) 1712 Melbourne Road			4b. City, Town, or Location of Death Dundalk		4c. County of Death Baltimore				
Funeral Director	5. Social Security Number 212-30-5466	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 74 Yrs.	If Under 1 Year Months Days Hours Min.	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) May 26, 1932	9. Birthplace (State or Foreign Country) Maryland			
	Usual Residence of Decedent Maryland Baltimore			10a. State Maryland			10b. County Baltimore	10c. City, Town or Location Dundalk	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
To Be Completed by Funeral Director	10e. Street and Number 1712 Melbourne Road			10f. Zip Code 21222		10g. Citizen of What Country? United States				
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: 12 years			13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: White		14. Race - American Indian, Black, White, etc. Specify:			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker			16b. Kind of Business/Industry Own Home			
	17. Father's Name (First, Middle, Last) Edward Watts					18. Mother's Name (First, Middle, Maiden Surname) Anna B. Hopkins				
	19a. Informant's Name/Relationship (Type, Print) Charles Marr (Son)			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8196 Gumtree Drive Dundalk, Maryland 21222						
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) Oak Lawn Cemetery			20b. Place of Disposition (Name of cemetery, crematory or other place)		Date 4/18/2007	20c. Location - City or Town, State Baltimore, Maryland			
	21. Signature of Funeral Service Licensee 			22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Avenue Dundalk, Maryland 21222						
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Metastatic Breast Cancer Approximate Interval Between Onset and Death 4 years									
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last hiver metastases Approximate Interval Between Onset and Death 1 year									
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown <input type="checkbox"/> Other (specify) 9					23d. Date of delivery Month Day Year		
Medical Certification: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
									24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
									24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) Residence							
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year) 28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred			
			28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) At home				28f. Location (Street and Number or Rural Route Number, City or Town, State) Baltimore			
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
	29b. Signature and title of certifier 		29c. License number D54413				29d. Date signed (Month, Day, Year) 04/16/07			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Young J. Lee 3001 S. Hanover St. Baltimore MD 21225									
State Registrar	31. Date filed (Month, Day, Year) APR 18 2007		32. Registrar's Signature 							

Baltimore, Maryland 21215-0036

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division or Vital Records, P.O. Box 68760, CS

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 12384

1 - For State Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last)					2. Date of Death Month Day Year	3. Time of Death	
	Herbert Morin, Sr.					April 14, 2007		5:45 PM M
Funeral Director	4a. Facility Name (If not institution, give street and number)					4b. City, Town, or Location of Death		4c. County of Death
	Gilchrist Center for Hospice Care					Towson		Baltimore
To Be Completed by Funeral Director	5. Social Security Number	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 88 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) 01/30/1919	9. Birthplace (State or Foreign Country) VA	
	Usual Residence of Decedent MD Baltimore					10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
10a. State	10b. County	10c. City, Town or Location Owings Mills					10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number 4321 Flint Hill Drive Apt. 104			10f. Zip Code 21117	10g. Citizen of What Country? United States				
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: W/WF		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 4		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Engineer		14. Race - American Indian, Black, White, etc. Specify: White				
17. Father's Name (First, Middle, Last) Joseph Morin				18. Mother's Name (First, Middle, Maiden Surname) Sadie Munday				
19a. Informant's Name/Relationship (Type, Print) Herbert Morin, Jr./Son			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3318 Offutt Road Randallstown, MD 21133					
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Chesapeake Crematory Inc.		Date Apr 17	20c. Location - City or Town, State Beltsville, Maryland		
21. Signature of Funeral Service Licensee Helen M. Gordon								
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) lung cancer								
23b. Part II. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								
23c. If yes, outcome pf pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown								
23d. Date of delivery Month Day Year								
23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown								
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No								
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								
26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) hospice								
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide								
28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No								
28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)								
28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier Helen M. Gordon								
29c. License number DO051926								
29d. Date signed (Month, Day, Year) 4/15/07								
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Helen M. Gordon MS 6565 N. Charles St Baltimore MD 21204								
31. Date filed (Month, Day, Year) APR 18 2007								
32. Registrar's Signature Jessica L. Gordan								

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit once.

Division or Vital Records, P.O. Box 68760, **AS**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit once.

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Amend #4c Per Phy G866 4/18/07 Certificate of Death
Registrar Amend #29c PerPhy G866 4/24/07 JH

Reg. No. 2007 12385

Physician /Medical Examiner		1. Decedent's Name (First, Middle, Last) JOHN MERRILL		2. Date of Death Month 04 Day 05 Year 2007	3. Time of Death 11:48 PM	
Funeral Director		4a. Facility Name (If not institution, give street and number) UNIVERSITY OF MARYLAND MEDICAL CENTER		4b. City, Town, or Location of Death BALTIMORE CITY	4c. County of Death BALTIMORE	
To Be Completed by Funeral Director		5. Social Security Number 580-66-1074	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 43 Yrs.	If Under 1 Year Months Days Hours Min.	
				8. Date of Birth (Month, Day, Year) 12, 12, 1943		
				9. Birthplace (State or Foreign Country) Maryland		
To Be Completed by Physician/Medical Examiner		10a. State Maryland		10b. County Harford	10c. City, Town or Location Abingdon	
		10e. Street and Number 2630 Laurel Valley Garth		10f. Zip Code 21009		
		10g. Citizen of What Country? USA		14. Race - American Indian, Black, White, etc. White		
		11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: 1961	13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: White	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Mechanical Engineer	16b. Kind of Business/Industry U.S. Government
		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+)	18. Mother's Name (First, Middle, Maiden Surname) Wauneti Jane (unk)		
		19a. Informant's Name/Relationship (Type, Print) Barbara A. Merrill / Wife	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2630 Laurel Valley Garth, Abingdon, Maryland 21009	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) Hilltop Service Corp.		
				Date 4-9-07	20c. Location - City or Town, State Towson, Maryland	
		21. Signature of Funeral Service Licensee 	22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009	23a. Part I Enter the disease, or complications, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		
				Approximate Interval Between Onset and Death months		
		a. Due to (or as a consequence of): respiratory failure	b. Due to (or as a consequence of): lung cancer	c. Due to (or as a consequence of):	d. Due to (or as a consequence of):	
		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	23c. If yes, outcome pf pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown <input type="checkbox"/> Other (specify) Unknown	23d. Date of delivery Month Day Year		
		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23e. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
				24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
		25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		26. Place of Death (Check only one)	
		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide	28a. Date of Injury (Month, Day Year) M	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred
		28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) At home		28f. Location (Street and Number or Rural Route Number, City or Town, State) Maryland 21009		
		29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.	29c. License number P19690		29d. Date signed (Month, Day, Year) 04/06/2007	
		29b. Signature and title of certifier 				
		31. Date filed (Month, Day, Year) APR 18 2007	32. Registrar's Signature 			

Baltimore, Maryland 21215-0036

Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural"; or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division or Vital Records, P.O. Box 68760, *ED*

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 12386

1- For State Registrar

Physician /Medical Examiner

Funeral Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
 Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year		3. Time of Death
<i>Marie Morris</i>		<i>Apr. 13, 2007</i>		<i>3:15 p.m.</i>
4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of Death		4c. County of Death
<i>Bon Secours Hospital</i>		<i>Baltimore</i>		<i>Baltimore</i>
5. Social Security Number		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <i>65 Yrs.</i>	If Under 1 Year Months Days Hours Min.
<i>219-38-4116</i>				
10a. State <i>MARYLAND</i>		10b. County <i>N/A</i>	10c. City, Town or Location <i>BALTIMORE CITY</i>	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
10e. Street and Number <i>3108 Reisterstown Rd. 1st Fl</i>		10f. Zip Code <i>21215</i>		10g. Citizen of What Country? <i>USA</i>
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: <i>10th GRADE</i>		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: <i>BLACK</i>
15. Decedent's Education (Specify only highest grade completed) <i>Elementary/Secondary (0-12) 10th GRADE</i>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>HOUSE KEEPER</i>		16b. Kind of Business/Industry <i>SELF-EMPLOYED</i>
17. Father's Name (First, Middle, Last) <i>CLARENCE</i>		18. Mother's Name (First, Middle, Maiden Surname) <i>MORRIS FRANCES WILLIAMS</i>		
19a. Informant's Name/Relationship (Type, Print) <i>TANYA MORRIS (DAUGHTER)</i>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>2306 WINCHESTER ST. APT. I BALTO. MD. 21216</i>		
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <i>Jacqueline E. Foote</i>		20b. Place of Disposition (Name of cemetery, crematory or other place) <i>MT. ZION CEME.</i>		Date <i>04-23-07</i>
21. Signature of Funeral Service Licensee <i>Jacqueline E. Foote</i>		22. Name and Address of Facility <i>SEPH H. BROWN JR. FUNERAL HOME 3940 N. FULTON AVE. BALTO. MD. 21217</i>		20c. Location - City or Town, State <i>LANSDOWNE, MD</i>
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		Approximate Interval Between Onset and Death		
a. Due to (or as a consequence of): <i>Sepsis</i>				
b. Due to (or as a consequence of): <i>Pneumonia</i>				
c. Due to (or as a consequence of): <i>Respiratory Failure</i>				
d.				
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown
				24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No
		28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) <i>Bon Secour Hospital</i>		28d. Describe how injury occurred <i>Baltimore, Maryland</i>
29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29c. License number <i>PS3250</i>		
29b. Signature and title of certifier <i>J. E. Foote</i>		29d. Date signed (Month, Day, Year) <i>4/13/2007</i>		
30. Name and address of person who completed cause of death (Item 23a), (Type, Print) <i>Bon Secour Hospital</i>		31. Date filed (Month, Day, Year) <i>APR 18 2007</i>		
		32. Registrar's Signature <i>Jean E. Foote</i>		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2007 12387

Reg. No.

1- For
State
Registrar

Physician
/Medical
Examiner

Funeral
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

1. Decedent's Name (First, Middle, Last) JAMES MAGUIRE				2. Date of Death Month Day Year 04 05 2007	3. Time of Death 0500 M
4a. Facility Name (If not institution, give street and number) MEMORIAL HOSPITAL				4b. City, Town, or Location of Death CUMBERLAND	
5. Social Security Number 020-20-3666		6. Sex M	7. Age (In yrs. last birthday) 79 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
				8. Date of Birth (Month, Day, Year) Jan 20 1928	
				9. Birthplace (State or Foreign Country) MA	
Usual Residence of Decedent MD Allegany				10d. Inside City Limits 1 Yes 2 No	
10a. State MD				10b. County Allegany	
10c. City, Town or Location Cumberland				10f. Zip Code 21502	
10e. Street and Number 610 Bedford Street				10g. Citizen of What Country? USA	
11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Navy If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No Specify:	
14. Race - American Indian, Black, White, etc. Specify: white		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12			
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Military				16b. Kind of Business/Industry Government	
17. Father's Name (First, Middle, Last) John H. Maguire				18. Mother's Name (First, Middle, Maiden Surname) Mary Murray	
19a. Informant's Name/Relationship (Type, Print) Florence Lucas				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6017 Bedford Street Cumberland, MD 21502	
20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Metro Crematory 4-18-07 Belto, MD	Date
21. Signature of Funeral Service Licensee ▶ June V. Ranch				20c. Location - City or Town, State 18434	
22. Name and Address of Facility ILAM 1232 Midvalley Dr. Jersup, PA				23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) CEREBROVASCULAR ACCIDENT	
				Approximate Interval Between Onset and Death 1 WK	
23b. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown				23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown	
				23d. Date of delivery Month Day Year	
23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown				23f. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				24a. Was an autopsy performed? 1 Yes 2 No	
				24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No	
25. Was case referred to medical examiner? 1 Yes 2 No				26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)	
27. Manner of Death 1 Natural 5 Pending investigation 2 Accident 6 Could not be determined 3 Suicide 4 Homicide				28a. Date of Injury (Month, Day Year) M	
				28b. Time of Injury 1 □ Yes 2 □ No	
28c. Injury at Work? 1 □ Yes 2 □ No				28d. Describe how injury occurred	
28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) At home				28f. Location (Street and Number or Rural Route Number, City or Town, State) WIRASAT HASNAIN, 900 SETON DR., CUMBERLAND, MD 21502	
29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29c. License number D 0063118	
29b. Signature and title of certifier ▶ WIRASAT HASNAIN M.D				29d. Date signed (Month, Day, Year) 04-05-2007	
31. Date filed (Month, Day, Year) APR 18 2007				32. Registrar's Signature ▶ June V. Ranch	

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 12388

1- For State Registrar

Physician /Medical Examiner

Funeral Director

Baltimore, Maryland 21215-0036

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

1. Decedent's Name (First, Middle, Last) <i>Robert Watkins</i>				2. Date of Death Month Day Year Apr 12 2007				3. Time of Death 1708 PM		
4a. Facility Name (If not institution, give street and number) <i>Union Memorial Hospital</i>				4b. City, Town or Location of Death <i>Baltimore</i>				4c. County of Death <i>N/A</i>		
5. Social Security Number <i>216-88-7789</i>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <i>46 Yrs.</i>		If Under 1 Year Months Days Hours Min.		8. Date of Birth Month, Day, Year <i>Aug. 2, 1960</i>		
9. Birthplace (State or Foreign Country) <i>Maryland</i>		10a. State <i>Maryland</i>		10b. County <i>N/A</i>		10c. City, Town or Location <i>Baltimore</i>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
10e. Street and Number <i>317 E. North Ave. Apt. 203</i>				10f. Zip Code <i>21201</i>				10g. Citizen of What Country? <i>USA</i>		
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <i>If Yes, Give Year or Dates:</i>				13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: <i>Specify:</i>				14. Race - American Indian, Black, White, etc. <i>Specify:</i>
15. Decedent's Education (Specify only highest grade completed) <i>Elementary/Secondary (0-12)</i>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Delivery Truck Driver</i>				16b. Kind of Business/Industry <i>Private</i>		
17. Father's Name (First, Middle, Last) <i>Levi Watkins</i>				18. Mother's Name (First, Middle, Maiden Surname) <i>Lela Helen Patterson</i>						
19a. Informant's Name/Relationship (Type, Print) <i>Mark Watkins - brother</i>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>1649 Darley Ave. Baltimore, Maryland 21213</i>						
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <i>Parker Funeral Home, P.A.</i>		20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Metro Crematory</i>				Date <i>4/12/07</i>	20c. Location - City or Town, State <i>Catonsville, Maryland</i>			
21. Signature of Funeral Service Licensee <i>John Parker</i>				22. Name and Address of Facility <i>3512 Frederick Ave. Baltimore, Maryland</i>						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.										
Immediate Cause (Final disease or condition resulting in death)										
23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown										
23c. If yes, outcome pf pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown <input type="checkbox"/> Other (specify) <i>Hyperkalemia</i> Due to (or as a consequence of):										
23d. Date of delivery Month Day Year										
23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown										
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										
26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)										
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide										
28a. Date of Injury (Month, Day Year) <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) 28b. Time of Injury M 28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No 28d. Describe how injury occurred										
28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)										
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
29b. Signature and title of certifier <i>Mark Watkins</i>										
29c. License number <i>ATZ438946</i>										
29d. Date signed (Month, Day, Year) <i>April 12, 2007</i>										
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Mark Watkins</i>										
31. Date filed (Month, Day, Year) <i>APR 18 2007</i>										
32. Registrar's Signature <i>Leanne H. Parker</i>										

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

33. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Mark Watkins</i>	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM #8 per FH G867, 5/2/07, WS

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 12389

1 - For State Registrar

Physician /Medical Examiner

Important: If Item 27 is marked other than "natural", or items 23a or 28a-d show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

1. Decedent's Name (First, Middle, Last)	Kasimira L. Nicholson				2. Date of Death Month Day Year <u>APRIL 17 2007</u>	3. Time of Death Hour Min. <u>3:08 P M</u>
4a. Facility Name (If not institution, give street and number) <u>BALTIMORE WASHINGTON MEDICAL CENTER</u>				4b. City, Town, or Location of Death <u>GLEN BURNIE</u>		4c. County of Death <u>ANNE ARUNDEL</u>
5. Social Security Number <u>024-40-2790</u>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F <u>XX</u>	7. Age (In yrs. last birthday) <u>61</u> Yrs.	If Under 1 Year Months <u>0</u>	If Under 24 Hrs. Days <u>0</u>	Hours <u>0</u>	Min. <u>0</u>
8. Date of Birth (Month, Day, Year) <u>1/26/1946</u>				9. Birthplace (State or Foreign Country) <u>April 17, 2007</u> Germany		
Usual Residence of Decedent						
10a. State <u>MD</u>	10b. County <u>Anne Arundel</u>	10c. City, Town or Location <u>Glen Burnie</u>				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <u>XX</u>
10e. Street and Number <u>7914 Allard Ct # 303</u>				10f. Zip Code <u>21061</u>		10g. Citizen of What Country? <u>USA</u>
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <u>XX</u> <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: <u>1960</u>		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: <u>White</u>		14. Race - American Indian, Black, White, etc. <u>White</u>
15. Decedent's Education (Specify only highest grade completed) <u>Elementary/Secondary (0-12)</u>			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <u>Food Prep</u>			16b. Kind of Business/Industry <u>Catering</u>
17. Father's Name (First, Middle, Last) <u>Antoni Lombarski</u>				18. Mother's Name (First, Middle, Maiden Surname) <u>Aneila Szewczyk</u>		
19a. Informant's Name/Relationship (Type, Print) <u>Barbara Nicholson Daughter in Law</u>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>3623 Chadwick Ct, Pasadena, MD 21122</u>		
20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <u>K. Gregory Fink M01148</u>		20b. Place of Disposition (Name of cemetery, crematory or other place) <u>Holy Cross Cemetery</u>		Date <u>4-20-2007</u>	20c. Location - City or Town, State <u>Brooklyn, MD</u>	
21. Signature of Funeral Service Licensee <u>K. Gregory Fink</u>		22. Name and Address of Facility <u>Fink Funeral Home, P.A.</u> <u>426 Crain Hwy S, Glen Burnie, MD 21061</u>				

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Division or Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-6836

5

State Registrar

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		Approximate Interval Between Onset and Death			
a. <u>METASTATIC OVARIAN CANCER</u> Due to (or as a consequence of): <u>SEPSIS</u>					
b. <u>TUMOR</u> Due to (or as a consequence of): <u>SEPSIS</u>					
c. <u>SEPSIS</u> Due to (or as a consequence of):					
d.					
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome pf pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown <input type="checkbox"/> Other (Specify) _____			
23d. Date of delivery Month Day Year					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					
		23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown			
		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred
		28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier <u>Dr. Linda J. MD</u>		29c. License number <u>045149</u>		29d. Date signed (Month, Day, Year) <u>April 17 2007</u>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <u>Dr. Linda J. MD</u>		31. Date filed (Month, Day, Year) <u>APR 18 2007</u>			
32. Registrar's Signature <u>Linda J. MD</u>					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2007 12390

1- For State Registrar		2. Date of Death Month Day Year										3. Time of Death	
Physician /Medical Examiner		April 15 2007										0025 M	
Funeral Director		4a. Facility Name (If not institution, give street and number) Good Samaritan Hospital										4b. City, Town, or Location of Death Baltimore	4c. County of Death Baltimore City
To Be Completed by Funeral Director		5. Social Security Number 218 22 8914		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 80 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) February 10 1927	9. Birthplace (State or Foreign Country) Baltimore, Maryland				
		10a. State Maryland		10b. County Baltimore		10c. City, Town or Location Baltimore City		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
		10e. Street and Number 3421 Chesley Avenue				10f. Zip Code 21234		10g. Citizen of What Country? USA					
		11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White					
		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) N/A Housewife		16b. Kind of Business/Industry Housekeeping-Own Home							
		17. Father's Name (First, Middle, Last) Raphael Casella		18. Mother's Name (First, Middle, Maiden Surname) Theresa Salerno									
		19a. Informant's Name/Relationship (Type, Print) Sharon Petr (Daughter)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3421 Chesley Avenue Baltimore, Maryland 21234									
		20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Parkwood Cemetery April 18 2007		20c. Location - City or Town, State Baltimore, Maryland							
		21. Signature of Funeral Service Licensee <i>Walter J. Casella</i>		22. Name and Address of Facility Lassahn Funeral Home Inc 7401 Belair Road Baltimore, Maryland 21236									
		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		23b. Due to (or as a consequence of): ACUTE MYOCARDIAL INFARCTION		Approximate Interval Between Onset and Death							
		{		23c. Due to (or as a consequence of): ATHEROSCLEROTIC CARDIOVASCULAR DISEASE									
		23d. Due to (or as a consequence of): d. _____											
		23e. IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year							
		23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown		23f. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No									
		25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. Manner of death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide							
		27. Manner of death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year) M 28b. Time of Injury 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred							
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)									
		29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <i>Joseph MD</i>		29c. License number D58933		29d. Date signed (Month, Day, Year) 4/15/2007					
		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JOSEPH MD 5601 LOCH RAVEN BLVD BALTIMORE MD 21238		32. Registrar's Signature <i>James B. Casella</i>									
Division of Vital Records, P.O. Box 68760, Medical Certification: To Be Completed by Physician/Medical Examiner		31. Date filed (Month, Day, Year) APR 18 2007		33. Registrar's Signature									
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit													
State Registrar													

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2007 12391

Reg. No.

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Gabriele Elsbeth Nickle							2. Date of Death Month 04 Day 15 Year 2007	3. Time of Death 06:25 AM		
	4a. Facility Name (If not institution, give street and number) Franklin Square Hospital			4b. City, Town, or Location of Death Rosedale			4c. County of Death Baltimore				
Funeral Director	5. Social Security Number 218-58-6175	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 55 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	Hours	Min.	8. Date of Birth (Month, Day, Year) Dec. 7, 1951	9. Birthplace (State or Foreign Country) Germany		
To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State Maryland 10b. County Harford 10c. City, Town or Location Aberdeen 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										
	10e. Street and Number 420 Hillcrest Drive				10f. Zip Code 21001			10g. Citizen of What Country? USA			
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+)		16b. Kind of Business/Industry Owner / Operator						
	17. Father's Name (First, Middle, Last) Gene Allen Sonnenburg					18. Mother's Name (First, Middle, Maiden Surname) Hilde (nmn) Werner					
	19a. Informant's Name/Relationship (Type, Print) Michael Nickle/ Husband					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 420 Hillcrest Drive, Aberdeen, MD 21001					
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Harford Memorial Grdn		Date 4-19-07	20c. Location - City or Town, State Aberdeen, Maryland					
	21. Signature of Funeral Service Licensee Charles A. Eddy					22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009					
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Lung - Pneumonia Due to (or as a consequence of): b. Lung Carcinoma Due to (or as a consequence of): c. _____ d. _____									Approximate Interval Between Onset and Death	
	23b. If female: Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown					23d. Date of delivery Month Day Year			
Medical Certification: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown			
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred				
	29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29b. Signature and title of certifier Kenneth Eddy MD		29c. License number RES 0000					29d. Date signed (Month, Day, Year) 4/15/2007			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Kenneth Eddy 9000 Franklin Square Drive, Balt., MD 21237										
	31. Date filed (Month, Day, Year) APR 18 2007		32. Registrar's Signature Leanne M. Farley								

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State of Maryland / Department of Health and Mental Hygiene

1- For State Amend #26, per MD, g866, 4/18/07 IT
Registrar

Certificate of Death

Reg. No.

2007 12392

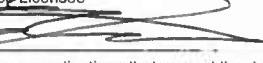
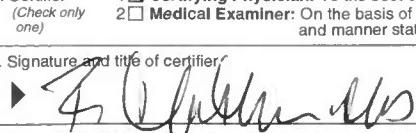
Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Kathlyn Margaret Oleniacz				2. Date of Death Month Day Year April 14, 2007	3. Time of Death 11:58 p.m.				
					4c. County of Death Baltimore					
Funeral Director	4a. Facility Name (If not institution, give street and number) 7803 St. Clair Lane			4b. City, Town, or Location of Death Dundalk						
	5. Social Security Number 215-30-7072	6. Sex 1 M 2 F	7. Age (In yrs. last birthday) 74 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) March 14, 1933	9. Birthplace (State or Foreign Country) Maryland			
To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State Maryland			10b. County Baltimore	10c. City, Town or Location Dundalk		10d. Inside City Limits 1 Yes 2 No			
	10e. Street and Number 1736 Burnham Road			10f. Zip Code 21222		10g. Citizen of What Country? United States				
	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No Specify:		14. Race - American Indian, Black, White, etc. Specify: White				
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 years		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Senior Clerk		16b. Kind of Business/Industry Accounting					
	17. Father's Name (First, Middle, Last) Henry Alfred Keitz			18. Mother's Name (First, Middle, Maiden Surname) Kathryne Trice						
	19a. Informant's Name/Relationship (Type, Print) Evelyn Zaworski (Sister)			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1736 Burnham Road Dundalk, Maryland 21222						
	20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Bel Air Mem. Gdns.		Date 4/19/2007	20c. Location - City or Town, State Bel Air, Maryland				
	21. Signature of Funeral Service Licensee Chalon J. R. Reilly		22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Avenue Dundalk, Maryland 21222							
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							Approximate Interval Between Onset and Death wks		
	<p>a. Left lower lobe Mass Due to (or as a consequence of):</p> <p>b. Bilateral pneumonia Due to (or as a consequence of):</p> <p>c. Chronic Renal Disease Due to (or as a consequence of):</p> <p>d. Hypertension Due to (or as a consequence of):</p>									
Medical Certification: To Be Completed by Physician/Medical Examiner	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown							23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown	23d. Date of delivery Month Day Year	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Congested Heart Failure, Anemia Cachexia, anoxia, Diabetes II Atrial Fibrillation, Gastric Reflux							23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown		
	25. Was case referred to medical examiner? 1 Yes 2 No							26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)	24a. Was an autopsy performed? 1 Yes 2 No	24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No
	27. Manner of Death 1 Natural 5 Pending investigation 2 Accident 6 Could not be determined 3 Suicide 4 Homicide		28a. Date of Injury (Month, Day, Year) M	28b. Time of Injury M	28c. Injury at Work? 1 Yes 2 No	28d. Describe how injury occurred				
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)							28f. Location (Street and Number or Rural Route Number, City or Town, State)		
	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
	29b. Signature and title of Certifier Allen Reilly, MD							29c. License number D 54749	29d. Date signed (Month, Day, Year) April 16, 2007	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Allen Reilly, MD 801 1011 House Ave, P.O. Box 21701									
State Registrar	31. Date filed (Month, Day, Year) APR 18 2007		32. Registrar's Signature Allen Reilly							

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State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar Amend #20a&b Per FH G866 4/27/07 Certificate of Death

Reg. No. 2007 12393

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Joseph Franklin Pakacki, Sr.							2. Date of Death Month 09 Day 17 Year 2007	3. Time of Death 08:42 AM	
	4a. Facility Name (If not institution, give street and number) FRANKLIN Square Hospital Center				4b. City, Town, or Location of Death Rosedale			4c. County of Death Baltimore		
Funeral Director	5. Social Security Number 214-40-3205	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 64 Yrs.	If Under 1 Year Months 0	If Under 24 Hrs. Days 0	Hours 0	Min. 0	8. Date of Birth (Month, Day, Year) 02/23/1943	9. Birthplace (State or Foreign Country) Maryland	
To Be Completed by Funeral Director	10a. State Maryland				10b. County Baltimore	10c. City, Town or Location Essex				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	10e. Street and Number 6 Cardinal Lane				10f. Zip Code 21221			10g. Citizen of What Country? U.S.A.		
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: White			14. Race - American Indian, Black, White, etc. Specify: White		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Foreman			16b. Kind of Business/Industry Construction					
	17. Father's Name (First, Middle, Last) Adam Pakacki				18. Mother's Name (First, Middle, Maiden Surname) Ada May Wilburn					
	19a. Informant's Name/Relationship (Type, Print) Charlotte Knotts-Pakacki (Wife)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6 Cardinal Lane, Baltimore, Maryland 21221					
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) Holly Hill Mem. Gard. 4/27/07				20b. Place of Disposition (Name of facility, city, state, zip code) Bayview Crematory, Inc. 04/21/2007			20c. Location - City or Town, State Baltimore, Maryland		
Physician /Medical Examiner	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Bruzdzinski Funeral Home, P.A. 1407 Old Eastern Avenue, Essex, Maryland 21221					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate cause (Final disease or condition resulting in death)				23b. Due to (or as a consequence of): Metastatic lung cancer					Approximate Interval Between Onset and Death 18 months
	23c. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				23d. Due to (or as a consequence of):					
	23e. Due to (or as a consequence of):				23f. Due to (or as a consequence of):					
	23g. Due to (or as a consequence of):				23h. Due to (or as a consequence of):					
	23i. Due to (or as a consequence of):				23j. Due to (or as a consequence of):					
	23k. Due to (or as a consequence of):				23l. Due to (or as a consequence of):					
	23m. Due to (or as a consequence of):				23n. Due to (or as a consequence of):					
	23o. Due to (or as a consequence of):				23p. Due to (or as a consequence of):					
	23q. Due to (or as a consequence of):				23r. Due to (or as a consequence of):					
	23s. Due to (or as a consequence of):				23t. Due to (or as a consequence of):					
	23u. Due to (or as a consequence of):				23v. Due to (or as a consequence of):					
	23w. Due to (or as a consequence of):				23x. Due to (or as a consequence of):					
	23y. Due to (or as a consequence of):				23z. Due to (or as a consequence of):					
	24a. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Don't know					
	24c. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				24d. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
	24e. Signature and title of certifier 				24f. License number D0057021					24g. Date signed (Month, Day, Year) 4/17/07
	24h. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rita Mathur, M.D. 9100 Philadelphia Rd. Ste #200 Baer, MD 21237				24i. Date filed (Month, Day, Year) APR 18 2007					
	24j. Registrar's Signature 				24k. Original					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 12394

For
State
Registrar

Physician / Medical Examiner	1. Decedent's Name (First, Middle, Last)				2. Date of Death				3. Time of Death		
	Arnetta O. Palmer				Month	Day	Year	11 15 2007		AM	
Funeral Director	4a. Facility Name (If not institution, give street and number)				4b. City, Town, or Location of Death				4c. County of Death		
	7110 Deerfield Rd.				Pikesville				Balto.		
5. Social Security Number		6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.			8. Date of Birth (Month, Day, Year)		9. Birthplace (State or Foreign Country)	
215-12-8887		<input type="checkbox"/> M <input checked="" type="checkbox"/> F	94 Yrs.		Months	Days	Hours	Min.	7-11-1912	Pennsylvania	
Usual Residence of Decedent											10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
10a. State		10b. County		10c. City, Town or Location							
Md		Balto.		Pikesville							
10e. Street and Number				10f. Zip Code				10g. Citizen of What Country?			
7110 Deerfield Rd.				21208				U.S.A.			
11. Marital Status		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: Black			
Elementary/Secondary (0-12)		15. Decedent's Education (Specify only highest grade completed) 12			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Cashier			16b. Kind of Business/Industry Retail			
17. Father's Name (First, Middle, Last)		18. Mother's Name (First, Middle, Maiden Surname)									
James A. Taylor		Elizabeth Mason									
19a. Informant's Name/Relationship (Type, Print)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)									
Crystal N. Fuller granddaughter		7110 Deerfield Rd. Pikesville, Md.									
20a. Method of Disposition		20b. Place of Disposition (Name of cemetery, crematory or other place)			Date			20c. Location - City or Town, State			
<input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		Balto. National Cem.			4-23-2007			Balto. Md.			
21. Signature of Funeral Service Licensee Carbon C. Douglass		22. Name and Address of Facility Carbon C. Douglass Funeral Supply 1701 McCulloh Balto. Md. 21217									
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.											Approximate Interval Between Onset and Death 10 months
Immediate Cause (Final disease or condition resulting in death)											
a. Due to (or as a consequence of): Multiple Myeloma											
b. Due to (or as a consequence of):											
c. Due to (or as a consequence of):											
d. _____											
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Unknown						23d. Date of delivery Month Day Year			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.											23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
											24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
											24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)									
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury	M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)						
29b. Signature and title of certifier Rudigo B. Ehrlich M.D.		29c. License number D0054911			29d. Date signed (Month, Day, Year) 04-16-2007						
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)											
Rudigo B. Ehrlich 2401 W. BELVEDERE Ave. BALTIMORE MD 21215											
31. Date filed (Month, Day, Year) APR 18 2007		32. Registrar's Signature James B. Ehrlich									

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit

Medical Certification: To Be Completed by Physician/Medical Examiner

within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2007 12395

1-For State
RegistrarPhysician/
Medical ExaminerFuneral
Director

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, MD 21215-0036

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,
To the Hospital or Attending Physician: The law requires that the death certificate be executedwithin 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit

		Certificate of Death															
		2. Date of Death Month Day Year April 10, 2007															
		3. Time of Death 0220 hrs															
1. Decedent's Name (First, Middle, Last)		4b. City, Town, or Location of Death				4c. County of Death											
Constantine John Plakas		Frederick				Frederick											
4a. Facility Name (if not institution, give street and number)		5. Social Security Number		6. Sex		7. Age (In yrs. last birthday)											
1900 Rosemont Avenue		579-18-1271		1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		87 Yrs.											
8. Date of Birth (MM/DD/YYYY)		9. Birthplace (State or Foreign Country)		If Under 1 Year		If Under 24 Hrs.											
November 25, 1919		Virginia		Months		Days Hours Min.											
10a. State		10b. County		10c. City, Town or Location													
Maryland		Montgomery		Rockville													
10d. Inside City Limits																	
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No																	
10e. Street and Number		10f. Zip Code				10g. Citizen of What Country?											
1214 Broadwood Drive		20851				United States											
11. Marital Status		12. Was Decedent Ever in U.S. Armed Forces?		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)				14. Race - American Indian, Black, White, etc.									
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married		1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No specify:				Specify: White									
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		If Yes, Give Year or Dates:															
15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)		16b. Kind of Business/Industry													
Elementary/Secondary (0-12)		College (1-4 or 5+)		Printer				United States Government									
2																	
17. Father's Name (First, Middle, Last)		18. Mother's Name (First, Middle, Maiden Surname)															
Konstantine John Plakas		Evedoxia Kyritses															
19a. Informant's Name/Relationship (Type, Print)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)															
James C. Plakas /Son		1214 Broadwood Drive, Rockville, Maryland 20851															
20a. Method of Disposition		20b. Place of Disposition (Name of cemetery, crematory or other place)		Date		20c. Location - City or Town, State											
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State		Gate of Heaven Cemetery		April 16, 2007		Silver Spring, Maryland											
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other Specify:																	
21. Signature of Funeral Service Licensee		22. Name and Address of Facility															
<i>William A. Humphrey</i>		Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue, Rockville, Maryland 20850-2805															
M01173																	
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																	
Immediate Cause (Final disease or condition resulting in death) a. Hypertensive atherosclerotic cardiovascular disease complicated																	
Due to (or as a consequence of): by femoral fracture																	
b. _____																	
Due to (or as a consequence of):																	
c. _____																	
Due to (or as a consequence of):																	
d. _____																	
<input type="checkbox"/> UNPENDED		<input type="checkbox"/> AMENDED #281, perME, g868, 6/28/07 TT		#28a, 27, 28a-f, perME, g868, 6/1/07 TT													
IF FEMALE:		23c. If yes, outcome of pregnancy				23d. Date of delivery											
23b. Was decedent pregnant in the past 12 months?		1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy				Month Day Year											
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify)															
9 <input type="checkbox"/> Unknown																	
23e. Did tobacco use contribute to the cause of death?																	
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown																	
24a. Was an autopsy performed?								24b. Were autopsy findings available prior to completion of cause of death?									
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> N								1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No									
25. Was case referred to medical examiner?		26. Place of Death (Check only one)															
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		Hospital: 1 <input type="checkbox"/> Inpatient		2 <input type="checkbox"/> ER/Outpatient		3 <input type="checkbox"/> DOA		4 <input type="checkbox"/> Nursing Home		5 <input type="checkbox"/> Residence		6 <input checked="" type="checkbox"/> Other Scene					
27. Manner of Death		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury		28c. Injury at Work?		28d. Describe how injury occurred									
1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation		unk		unk		1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		subject injured leg									
2 <input checked="" type="checkbox"/> Accident		3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined		(Specify) Rehabilitation Center													
4 <input type="checkbox"/> Homicide		28e. Place of Injury - At home, farm, street, factory, office building, etc.						28f. Location (Street and Number or Rural Route Number, City or Town, State)		200 E. 16th Street							
								1900 Rosemont Ave.		Frederick, MD							
29a. Certifier 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one)		29b. Signature and title of certifier										29c. License number				29d. Date signed (Month, Day, Year)	
2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		<i>Zabiullah Ali, M.D.</i>										O.C.M.E.				April 16, 2007	
30. Name and address of person who completed cause of death (Item 23a)																	
Zabiullah Ali, M.D. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201																	
31. Date filed (Month, Day, Year)		32. Registrar's Signature															
APR 18 2007		<i>James B. Jones</i>															

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2007 12396

Reg. No.

1-
For
State
Registrar

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)	MARY H. ROSS				2. Date of Death Month April Day 17 Year 2007	3. Time of Death 6:44 AM
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Funeral
Director

4a. Facility Name (If not institution, give street and number)	Sinai Hospital of Baltimore				4b. City, Town, or Location of Death Baltimore	4c. County of Death N/A
5. Social Security Number 216-16-1133	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 82 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) 10/17/1924	9. Birthplace (State or Foreign Country) N. CAROLINA

Usual Residence of Decedent
10a. State MD
10b. County N/A
10c. City, Town or Location BALTIMORE CITY
10d. Inside City Limits
 Yes No

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

10e. Street and Number 5514 CADILLAC AVENUE	10f. Zip Code 21207	10g. Citizen of What Country? USA
--	------------------------	--------------------------------------

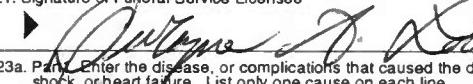
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc. 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:	14. Race - American Indian, Black, White, etc. Specify: BLACK
--	---	--	--

15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) CLERK	16b. Kind of Business/Industry C&P PHONE COMPANY
--	---	---

17. Father's Name (First, Middle, Last) LEMON SHAW	18. Mother's Name (First, Middle, Maiden Surname) REBECCA BARNES
---	---

19a. Informant's Name/Relationship (Type, Print) VERONIC ROSS-WHITE/DAUGHTER	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5514 CADILLAC AVE., BALTIMORE, MD 21207
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20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)	20b. Place of Disposition (Name of cemetery, crematory or other place) WOODLAWN CEMETERY	Date 4/23/07	20c. Location - City or Town, State BALTIMORE CO. MD
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21. Signature of Funeral Service Licensee 	22. Name and Address of Facility HOWELL FUNERAL HOME 21207 4600 LIBERTY HEIGHTS AVE, BALTIMORE MD
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23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)	Approximate Interval Between Onset and Death
a. Due to (or as a consequence of): Aspiration Pneumonia	
b. Due to (or as a consequence of):	
c. Due to (or as a consequence of):	
d. Due to (or as a consequence of):	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown	23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown	23d. Date of delivery Month Day Year
--	---	---

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Cerebrovascular Accident	23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown
Hyper tension	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
COPD	24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No

25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)	26. Place of Death (Check only one)
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27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.	29c. License number DO5962	29d. Date signed (Month, Day, Year) April 17, 2007
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30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Chad Hansen, MD 2401 W Belvedere, Baltimore MD 21215	32. Registrar's Signature 
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31. Date filed (Month, Day, Year) APR 18 2007	32. Registrar's Signature
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ORIGINAL

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760, MD

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit document.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene
2007 12397
Certificate of Death1- For
State
Registrar

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year				3. Time of Death	
Mario Thomas Rossilli	April 15, 2007				21:36 M	
4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death				4c. County of Death	
Upper Chesapeake Medical Center	Bel Air				Harford	
5. Social Security Number	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 71 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days Hours Min.	8. Date of Birth (Month, Day, Year) June 4, 1935	9. Birthplace (State or Foreign Country) New York

Funeral
Director

Usual Residence of Decedent		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
10a. State Maryland	10b. County Harford	10c. City, Town or Location Joppa					
10e. Street and Number 1823 Atkisson Road		10f. Zip Code 21085		10g. Citizen of What Country? USA			
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	14. Race - American Indian, Black, White, etc. Specify: USA				
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Owner/Operator	16b. Kind of Business/Industry Body Shop					
17. Father's Name (First, Middle, Last) Caesar (nmn) Rossilli		18. Mother's Name (First, Middle, Maiden Surname) Rose Helen DeBenedictus					
19a. Informant's Name/Relationship (Type, Print) Carol Rossilli/ Wife		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1823 Atkisson Road, Joppa, Maryland 21085					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)	20b. Place of Disposition (Name of cemetery, crematory or other place) Bel Air Memorial Grdn 4-20-07	Date	20c. Location - City or Town, State Bel Air, Maryland				
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009					

To Be Completed by Funeral Director

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		Approximate Interval Between Onset and Death one hour				
<p>a. <i>Electro magnetic Dis Association</i> Due to (or as a consequence of):</p> <p>b. <i>Ischemic Heart Disease</i> Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. _____</p>						
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____				
		23d. Date of delivery Month Day Year				
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29b. Signature and title of certifier 		29c. License number D 0053720		29d. Date signed (Month, Day, Year) 04/16/2007		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) S. Rogers, Jr., 602, South Atwood Rd, #106, Belair, MD 21014						
31. Date filed (Month, Day, Year) APR 18 2007		32. Registrar's Signature 				

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit slip.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760, Es.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene
Certificate of Death

Reg. No.

2007 12398

1- For State Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Chinglepet P. Ranganathan							2. Date of Death Month Day Year April 14, 2007	3. Time of Death 8:11 PM	
	4a. Facility Name (If not institution, give street and number) Suburban Hospital				4b. City, Town, or Location of Death Bethesda			4c. County of Death Montgomery		
Funeral Director	5. Social Security Number 579-74-8818	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 73 Yrs.	If Under 1 Year Months Days Hours Min.	8. Date of Birth (Month, Day, Year) August 9, 1933			9. Birthplace (State or Foreign Country) India		
To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State Maryland 10b. County Montgomery				10c. City, Town or Location Rockville				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
	10e. Street and Number 5901 Empire Way				10f. Zip Code 20852			10g. Citizen of What Country? India		
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: Asian-Indian		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 5+				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Engineer			16b. Kind of Business/Industry World Bank		
	17. Father's Name (First, Middle, Last) C. Ponnurangam				18. Mother's Name (First, Middle, Maiden Surname) Ranganayaki Ammal					
	19a. Informant's Name/Relationship (Type, Print) Saraswathi Ranganathan/wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5901 Empire Way Rockville, Maryland 20852					
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) West Arundel Crematory			Date 4/16/2007	20c. Location - City or Town, State Odenton, Maryland			
	21. Signature of Funeral Service Licensee <i>Quanta R Thomas</i>				22. Name and Address of Facility Donaldson Funeral Home & Crematory, P.A. 1411 Annapolis Road Odenton, Maryland 21113					
Physician /Medical Examiner	23a. Part I Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death	
	<p>a. Due to (or as a consequence of): <i>Anoxic Encephalopathy</i></p> <p>b. Due to (or as a consequence of): <i>Respiratory failure</i></p> <p>c. Due to (or as a consequence of): <i>Pneumonia</i></p> <p>d. Due to (or as a consequence of): <i>Acute Renal failure</i></p>									
Medical Certification: To Be Completed by Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome pf pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown <input type="checkbox"/> Other (specify) _____					23d. Date of delivery Month Day Year		
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>cardiomyopathy</i>								23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
									24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
									24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred			
			28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)					
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
	29b. Signature and title of certifier <i>Ajay Renny</i>		29c. License number D53691						29d. Date signed (Month, Day, Year) April 15, 2007	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AJAY RENNY MD, 6320 Democracy Blvd, Bethesda, MD. 20811									
State Registrar	31. Date filed (Month, Day, Year) APR 18 2007		32. Registrar's Signature <i>Jeanne K. Foster</i>							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2007 12399

1- For State Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) FRANK A. ROYAL					2. Date of Death Month April Day 15 Year 2007	3. Time of Death 10 a M			
	4a. Facility Name (If not institution, give street and number) 11 S. BEACHFIELD AVE. APT.C					4b. City, Town, or Location of Death Baltimore	4d. County of Death N/A			
Funeral Director	5. Social Security Number 219-92-4738		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 40 Yrs.	If Under 1 Year Months 0 Days 0	If Under 24 Hrs. Hours 0 Min. 0	8. Date of Birth (Month, Day, Year) DEC. 13, 1966	9. Birthplace (State or Foreign Country) Maryland		
	10a. State Md.		10b. County N/A		10c. City, Town or Location Baltimore			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
To Be Completed by Funeral Director	10e. Street and Number 11 S. Beechfield Ave. Apt. C			10f. Zip Code 21229		10g. Citizen of What Country? USA				
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: 12th N/A			13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: Black			14. Race - American Indian, Black, White, etc.			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Security Guard			16b. Kind of Business/Industry Security			
17. Father's Name (First, Middle, Last) Frank Royal				18. Mother's Name (First, Middle, Maiden Surname) Anna HOLT						
19a. Informant's Name/Relationship (Type, Print) Lorraine Johnson - Sister					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4702 Dartford Ave Baeto. md. 21229					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) MT. Zion Cem. 4-21-07			Date 4-21-07	20c. Location - City or Town, State Lansdowne, md.				
21. Signature of Funeral Service Licensee Gary P. March					22. Name and Address of Facility 270 Federation Pass Gary P. March Funeral Home Baeto. md. 21229					
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) ADVANCED HIV Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last a. Due to (or as a consequence of): ADVANCED HIV b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):							Approximate Interval Between Onset and Death MONTES		
Division or Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036	IF FEMALE:		23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown			23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year		
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. HEPATITIS C DIABETES MELLITUS TYPE 2							23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		
Medical Certification: To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide			28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred
2	29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) KOLLI RAMESH 9005 CATONS AVE, BALTIMORE, MD 21229			28f. Location (Street and Number or Rural Route Number, City or Town, State)				
State Registrar	29b. Signature and title of certifier Ramesh MD			29c. License number P17602			29d. Date signed (Month, Day, Year) APR 17 2007			
DHMH 17 Rev 1/2001	31. Date filed (Month, Day, Year) APR 18 2007		32. Registrar's Signature Sandra B. Spangler							

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 12400

**1- For
State
Registrar**

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) VONZELLA STOKES				2. Date of Death Month April Day 17 Year 2007	3. Time of Death 4:10 PM			
	4a. Facility Name (If not institution, give street and number) NORTHWEST HOSPITAL		4b. City, Town, or Location of Death RANDALLSTOWN		4c. County of Death RANDALLSTOWN, MD				
Funeral Director	5. Social Security Number 212-44-0418		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 62 Yrs.	8. Date of Birth (Month, Day, Year) 12/28/44	9. Birthplace (State or Foreign Country) MARYLAND			
	10a. State Md		10b. County Baltimore Co.	10c. City, Town or Location CATONSVILLE		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
To Be Completed by Funeral Director	10e. Street and Number 924 PRESTWOOD RD		10f. Zip Code 21228		10g. Citizen of What Country? USA				
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: 1981		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: BLACK		14. Race - American Indian, Black, White, etc.		
Physician /Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) COSMETOLOGIST		16b. Kind of Business/Industry BEAUTY SALON OPERATOR				
	17. Father's Name (First, Middle, Last) CLARENCE TAYLOR		18. Mother's Name (First, Middle, Maiden Surname) MARGARET ADDISON		19a. Informant's Name/Relationship (Type, Print) DAUGHTER CHAKAKHAI ROBISON		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 924 PRESTWOOD RD CATONSVILLE, MD 21228		
Medical Certification: To Be Completed by Physician/Medical Examiner	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) METRO CREMATORIUM 2307		20b. Place of Disposition (Name of cemetery, crematory or other place) METRO CREMATORIUM 2307		Date	20c. Location - City or Town, State CATONSVILLE, MD			
	21. Signature of Funeral Service Licensee Clarence Taylor		22. Name and Address of Facility HOWELL FUNERAL HOME 4600 LIBERTY HEIGHTS AV, BALTIMORE, MD 21207		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) CIRRHOSIS				
Medical Certification: To Be Completed by Physician/Medical Examiner	23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year				
	23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						
Medical Certification: To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
	27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year) M		28b. Time of Injury 1 □ Yes 2 □ No	28c. Injury at Work? 1 □ Yes 2 □ No			28d. Describe how injury occurred
Medical Certification: To Be Completed by Physician/Medical Examiner	28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) At home		28f. Location (Street and Number or Rural Route Number, City or Town, State) MIRCEA TODOR NORTHWEST HOSPITAL 5401 OLD COURT ROAD RANDALLSTOWN MD 21133						
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29c. License number D54352		29d. Date signed (Month, Day, Year) APRIL 17 2007				
State Registrar	31. Date filed (Month, Day, Year) APR 18 2007		32. Registrar's Signature [Signature]						
	ORIGINAL								

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 28a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2007 12401

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>John Leo Swedo</i>						2. Date of Death Month Day Year <i>April 12 2007</i>			3. Time of Death <i>11:39 PM</i>	
	4a. Facility Name (If not institution, give street and number) <i>Baltimore VA Medical Center</i>			4b. City, Town, or Location of Death <i>Baltimore</i>			4c. County of Death <i>N/A</i>				
Funeral Director	5. Social Security Number <i>187-16-2075</i>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <i>84</i>	If Under 1 Year Months <i>Yrs.</i>	If Under 24 Hrs. Hours <i>Min.</i>	8. Date of Birth (Month, Day, Year) <i>Feb. 1, 1923</i>	9. Birthplace (State or Foreign Country) <i>Pennsylvania</i>				
Usual Residence of Decedent										10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10a. State <i>Maryland</i>		10b. County <i>Baltimore</i>		10c. City, Town or Location <i>Edgemere</i>				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
10e. Street and Number <i>2825 Lodge Farm Road, Apt. 220</i>				10f. Zip Code <i>21219</i>			10g. Citizen of What Country? <i>United States</i>				
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: <i>1945-1948</i>			13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: <i>White</i>			14. Race - American Indian, Black, White, etc. Specify: <i>White</i>			
15. Decedent's Education (Specify only highest grade completed) <i>Elementary/Secondary (0-12) 8 years</i>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Painter</i>				16b. Kind of Business/Industry <i>Construction</i>			
17. Father's Name (First, Middle, Last) <i>Gabriel Swedo</i>					18. Mother's Name (First, Middle, Maiden Surname) <i>Mary Vochik</i>						
19a. Informant's Name/Relationship (Type, Print) <i>John L. Swedo, Jr. (Son)</i>					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>9 Hickory Hill Way West Granby, Connecticut 06090</i>						
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <i>St. Charles</i>				20b. Place of Disposition (Name of cemetery, crematory or other place) <i>St. Charles</i>			Date <i>4/20/2007</i>	20c. Location - City or Town, State <i>Long Island, New York</i>			
21. Signature of Funeral Service Licensee <i>Jean C. Collier</i>										22. Name and Address of Facility <i>Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Avenue Dundalk, Maryland 21222</i>	
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.										Approximate Interval Between Onset and Death <i>2 weeks</i>	
<p>Immediate Cause (Final disease or condition resulting in death) <i>COPD exacerbation</i></p> <p>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</p> <p>a. <i>COPD exacerbation</i> Due to (or as a consequence of):</p> <p>b. <i>pneumonia</i> Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d.</p>											
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown				23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year				
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown	
23f. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA			Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred					
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.											
29b. Signature and title of certifier <i>Megan E. Collins MD</i>				29c. License number <i>P21182</i>			29d. Date signed (Month, Day, Year) <i>Apr. 12, 2007</i>				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Megan E. Collins MD</i>										10 North Greene Street Baltimore, MD 21201	
31. Date filed (Month, Day, Year) <i>APR 18 2007</i>				32. Registrar's Signature <i>Frank H. Miller</i>							

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit once.

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
 Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 12402

1- For
State
Registrar

Physician
/Medical
Examiner

Funeral
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year		3. Time of Death
<i>Mary Jane Scott</i>		04-13-2007		7:40 PM
4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of Death		4c. County of Death
<i>Futurecare Sandtown</i>		<i>Baltimore</i>		
5. Social Security Number	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <i>100</i> Yrs.	If Under 1 Year Months Days Hours Min.	8. Date of Birth (Month, Day, Year) <i>08-14-1906</i>
				9. Birthplace (State or Foreign Country) <i>MD</i>
10a. State <i>MD</i>	10b. County	10c. City, Town or Location <i>Baltimore</i>	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number <i>11 W. 20th Street</i>		10f. Zip Code <i>Baltimore</i>	10g. Citizen of What Country? <i>USA</i>	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: <i>5th</i>	13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	14. Race - American Indian, Black, White, etc. Specify: <i>Black</i>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>5th</i>	College (1-4 or 5+) <i></i>	16a. Decedent's Usual Occupation (Give kind of work done during most of working life - DO NOT use retired) <i>Foster Parent</i>	16b. Kind of Business/Industry <i>Baltimore City</i>	
17. Father's Name (First, Middle, Last) <i>Howard Hunt</i>		18. Mother's Name (First, Middle, Maiden Surname) <i>Etta Hunt</i>		
19a. Informant's Name/Relationship (Type, Print) <i>Mary L. Parker (Cousin)</i>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>1904 Swansea Rd., Baltimore, MD 21239</i>		
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Green Mount</i>	Date	20c. Location - City or Town, State <i>4120107 Baltimore, MD</i>
21. Signature of Funeral Service Licensee <i>Vaughn C. Greene</i>		22. Name and Address of Facility <i>Vaughn C. Greene Funeral Services 5151 Baltimore Nat'l Pike, Baltimore, MD 21229</i>		
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		Approximate Interval Between Onset and Death		
23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome pf pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown		
23d. Date of delivery Month Day Year				
23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown				
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No
		28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <i>ATTENDING</i>		
		29c. License number <i>D0056948</i>		29d. Date signed (Month, Day, Year) <i>APRIL 17 2007</i>
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)		<i>JANE JANNINA AND JOAN ARNOVA PLACE BALTIMORE MD 21217</i>		
31. Date filed (Month, Day, Year) <i>APR 18 2007</i>		32. Registrar's Signature <i>[Signature]</i>		

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2007 12403

1- For State
Registrar

Reg. No.

**Physician/
Medical Examiner**

1. Decedent's Name (First, Middle, Last)

Shane Michael Snyder

2. Date of Death

Month

Day

Year

April 12, 2007

3. Time of Death

1215 hrs

**Funeral
Director**

4a. Facility Name (if not institution, give street and number)

Sinai Hospital

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

5. Social Security Number

213-27-7704

6. Sex

1 M 2 F

7. Age (In yrs. last birthday)

22 Yrs.

If Under 1 Year

Months Days Hours Min.

8. Date of Birth (MM/DD/YYYY)

June 7, 1984

9. Birthplace (State or
Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Edgemere

10d. Inside City Limits

1 Yes 2 No

10e. Street and Number

9307 Sea Point Road

10f. Zip Code

21219

10g. Citizen of What Country?

United States

11. Marital Status

1 Never Married2 Married

12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No

If Yes, Give Year or Dates

3 Widowed4 Divorced

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 Yes 2 No specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12 years

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

College (1-4 or 5+)

Cook

16b. Kind of Business/Industry

Restaurant

17. Father's Name (First, Middle, Last)

Alan R. Snyder

18. Mother's Name (First, Middle, Maiden Surname)

Jo Ann D. Lang

19a. Informant's Name/Relationship (Type, Print)

Alan R. Snyder (Father)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

9307 Sea Point Road Edgemere, Maryland 21219

20a. Method of Disposition

1 Burial2 Cremation3 Removal from State

20b. Place of Disposition (Name of cemetery, crematory or other place)

Druid Ridge Cemetery

Date

4/16/2007

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

John A. Jones

22. Name and Address of Facility

Duda-Ruck Funeral Home of Dundalk, Inc.

7922 Wise Avenue Dundalk, Maryland 21222

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Hydrocodone, chlorpheniramine and diazepam intoxication

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

UNPENDED

AMENDED

#23a, 27, 28a-f, per ME, g86, 4/19/07 TT

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 Yes2 No9 Unknown

23c. If yes, outcome of pregnancy

1 Live birth2 Fetal death3 Ectopic pregnancy4 Pregnant at time of death5 Other (Specify)9 Unknown

23d. Date of delivery

Month

Day

Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 Yes2 No3 Probably4 Unknown

23f. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. Was an autopsy performed?

1 Yes2 No

24b. Were autopsy findings available prior to completion of cause of death?

1 Yes2 No

25. Was case referred to medical examiner?

1 Yes2 No

26. Place of Death (Check only one)

Hospital: 1 Inpatient 2 ER/Outpatient 3 DOAOther: 4 Nursing Home 5 Residence 6 Other

27. Manner of Death

1 Natural2 Accident3 Suicide4 Homicide5 Pending Investigation6 Could not be determined

28a. Date of Injury (Month, Day, Year)

4.12.2007

28b. Time of Injury

Fnd 11:19 am

28c. Injury at Work?

1 Yes 2 No

unk

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc.

(Specify) grandfather's residence

28f. Location (Street and Number or Rural Route Number, City or Town, State)

6350 Red Cedar Pl. Baltimore, MD

29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

and manner stated

29b. Signature and title of certifier

Tasha Greenberg MD. Assistant Medical Examiner

111 Penn Street, Baltimore, MD 21201

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

April 13, 2007

31. Date filed (Month, Day, Year)

APR 18 2007

32. Registrar's Signature

John A. Jones

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

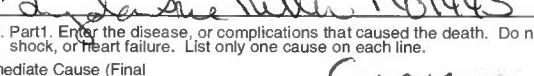
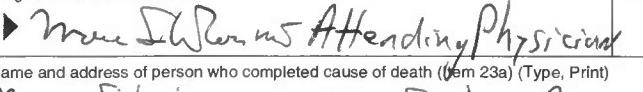
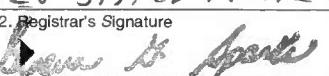
**1- For
State
Registrar**

Amend #11 Per Inf G866 4/20/07 Jh State of Maryland / Department

Certificate of Death

Reg. No. 20007 201

Baltimore, Maryland 21215-0036

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Robert William Shrader							2. Date of Death Month 04 Day 14 Year 2007	3. Time of Death 6:47 A M	
	4a. Facility Name (If not institution, give street and number) Upper Chesapeake Hospital				4b. City, Town, or Location of Death Bel Air			4c. County of Death Harford		
Funeral Director	5. Social Security Number 216-44-1571		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 59 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) 04/21/1947	9. Birthplace (State or Foreign Country) MD		
	Usual Residence of Decedent 10a. State MD		10b. County Harford		10c. City, Town or Location Bel Air			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
10e. Street and Number 1006 Markham Ct. Unit B				10f. Zip Code 21014			10g. Citizen of What Country? USA			
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input checked="" type="checkbox"/> Separated <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: Year			13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: White			14. Race - American Indian, Black, White, etc.		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Truck Driver			16b. Kind of Business/Industry Self Employed			
17. Father's Name (First, Middle, Last) Elmer Charles Shrader				18. Mother's Name (First, Middle, Maiden Surname) Josephine C. Baker						
19a. Informant's Name/Relationship (Type, Print) Paula M. Shrader/Wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1006 Markham Ct. Unit B Bel Air, MD 21014						
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) Chesapeake Crematory Inc. 2007				20b. Place of Disposition (Name of cemetery, crematory or other place) Chesapeake Crematory Inc.			Date Apr 17	20c. Location - City or Town, State Beltsville, Maryland		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Cremation and Funeral Alternatives 8717 Green Pastures Drive Baltimore, Maryland 21286						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Coronary artery disease									Approximate Interval Between Onset and Death 15 years	
23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown										
23c. If yes, outcome pf pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown									23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown	
									24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred				
		28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)					28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
29b. Signature and title of certifier 		29c. License number D 26534			29d. Date signed (Month, Day, Year) 4/16/07					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mark Silverman MD 120 Sister Prince Dr. #105 Towson MD 21204										
31. Date filed (Month, Day, Year) APR 18 2007		32. Registrar's Signature 								

Division or Vital Records, P.O. Box 68760, *Tucson*

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

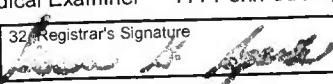
Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2007 12405

Physician/ Med. Examiner		Certificate of Death									
		Reg. No. SABB									
1. For State Registrar		2. Date of Death Month April 10, 2007 Day Year					3. Time of Death 1300 hrs				
1. Decedent's Name (First, Middle, Last)		4b. City, Town, or Location of Death Baltimore					4c. County of Death NIA				
4a. Facility Name (if not institution, give street and number) Union Memorial Hospital		5. Social Security Number 215-84-6909		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 44 yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (MM/DD/YYYY) DEC. 30, 1962	9. Birthplace (State or Foreign Country) MARYLAND		
Usual Residence of Decedent		10a. State MARYLAND		10b. County NIA	10c. City, Town or Location BALTIMORE CITY		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				
10e. Street and Number 2813 ROCKROSE AVENUE		10f. Zip Code 21215		10g. Citizen of What Country? USA							
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: 12TH GRADE		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No specify: DISABLED			14. Race - American Indian, Black, White, etc. Specify: BLACK				
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) FRANCE PRINTING CO.		16b. Kind of Business/Industry							
17. Father's Name (First, Middle, Last) WILLIE JACOB SABB		18. Mother's Name (First, Middle, Maiden Surname) QUEEN WILSON									
19a. Informant's Name/Relationship (Type, Print) QUEEN SABB (MOTHER)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2813 ROCKROSE AVE., BALTO, MD. 21215									
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other Specify: Jacqueline E Roane		20b. Place of Disposition (Name of cemetery, crematory or other place) MT. ZION CEMETERY		Date 04-26-07			20c. Location - City or Town, State LANSDOWNE, MD				
21. Signature of Funeral Service Licensee		22. Name and Address of Facility J. BROWN JR. FUNERAL HOME 2948 N. FAIRDALE AVE., BALTO, MD. 21217									
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. HIV Infection/AIDS		Approximate Interval Between Onset and Death							
Due to (or as a consequence of): Complications of seizure disorder											
b. Due to (or as a consequence of):											
c. Due to (or as a consequence of):											
d. Due to (or as a consequence of):											
<input checked="" type="checkbox"/> UNPENDED		<input checked="" type="checkbox"/> AMENDED #2a, PII, 27, 28a-f, per ME, g866, 4/26/07 TT									
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) _____ g <input type="checkbox"/> Unknown					23d. Date of delivery Month Day Year				
24a. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No									
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other:									
27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input checked="" type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Homicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year) Apr 4/3/2007		28b. Time of Injury unk	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred unk					
		28e. Place of Injury - At home, farm, street, factory, office building, etc. unk					28f. Location (Street and Number or Rural Route Number, City or Town, State) unk				
29a. Certifier 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) April 17, 2007							
29b. Signature and title of certifier Ana Rubio MD											
30. Name and address of person who completed cause of death (Item 23a) Ana Rubio MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201											
State Registrar		31. Date filed (Month, Day, Year) APR 18 2007		32. Registrar's Signature 		ORIGINAL					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 12406

1- For
State
RegistrarPhysician
/Medical
ExaminerFuneral
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

		1. Decedent's Name (First, Middle, Last)						2. Date of Death		3. Time of Death		
		Mardell Priscilla Smith						Month April Day 14 th Year 2007		6:30 AM		
		4a. Facility Name (If not institution, give street and number)			4b. City, Town, or Location of Death			4c. County of Death				
		BELAIR HEALTH/REHAB			BELAIR			HARFORD				
5. Social Security Number		6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year			8. Date of Birth			9. Birthplace (State or Foreign Country)		
220-20-6079		<input type="checkbox"/> M <input checked="" type="checkbox"/> F	78 Yrs.	Months Days Hours Min.			Month Day Year			Maryland		
Usual Residence of Decedent		10a. State		10b. County		10c. City, Town or Location					10d. Inside City Limits	
		Maryland		Harford		Bel Air					<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number						10f. Zip Code			10g. Citizen of What Country?			
16 N. Reed Street						21014			USA			
11. Marital Status		12. Was Decedent Ever in U.S. Armed Forces?			13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)			14. Race - American Indian, Black, White, etc.				
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:			1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			Specify: White				
15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)			16b. Kind of Business/Industry							
Elementary/Secondary (0-12) 7		College (1-4 or 5+) Presser						Clothing Manufacturer				
17. Father's Name (First, Middle, Last)		18. Mother's Name (First, Middle, Maiden Surname)										
George Washington Busler		Effie Ray Badders										
19a. Informant's Name/Relationship (Type, Print)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)										
George L. Smith / Son		16 N. Reed Street, Bel Air, Maryland 21014										
20a. Method of Disposition		20b. Place of Disposition (Name of cemetery, crematory or other place)			Date			20c. Location - City or Town, State				
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		Bel Air Memorial Grdn. 4-17-07						Bel Air, Maryland				
21. Signature of Funeral Service Licensee		22. Name and Address of Facility										
Charles A. Busler		McComas Funeral Home, P.A.										
23a. Part I. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.		23b. Approximate Interval Between Onset and Death										
Immediate Cause (Final disease or condition resulting in death)		Ovarian cancer										
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		a. Due to (or as a consequence of):										
		b. Due to (or as a consequence of):										
		c. Due to (or as a consequence of):										
		d. Due to (or as a consequence of):										
IF FEMALE:		23c. If yes, outcome of pregnancy			23d. Date of delivery							
23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown		1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown			Month Day Year							
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					23e. Did tobacco use contribute to the cause of death?							
					1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown							
25. Was case referred to medical examiner?		26. Place of Death (Check only one)										
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)										
27. Manner of Death		28a. Date of Injury (Month, Day, Year)			28b. Time of Injury			28c. Injury at Work?			28d. Describe how injury occurred	
1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined		M			M			1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No				
		28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)									28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one)		29b. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 1 <input checked="" type="checkbox"/> Certifying Physician: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 <input type="checkbox"/> Medical Examiner			Robert A. Duncan			29c. License number			29d. Date signed (Month, Day, Year)	
		Robert A. Duncan			D 28136			4-14-07				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)		31. Date filed (Month, Day, Year)			32. Registrar's Signature							
Robert A. Duncan		APR 18 2007			James H. Jones							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

12407

For State Registrar		State of Maryland / Department of Health and Mental Hygiene					Certificate of Death			Reg. No.	2007	12407
1. Decedent's Name (First, Middle, Last)		Gertrude Silverberg			2. Date of Death				3. Time of Death			
					Month April		Day 16th		Year 2007			
4a. Facility Name (If not institution, give street and number)		Howard County General Hosp.			4b. City, Town, or Location of Death		Columbia		4c. County of Death			
Howard		Howard							Howard			
5. Social Security Number		6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year		If Under 24 Hrs.		8. Date of Birth		9. Birthplace (State or Foreign Country)		
261-36-1869		<input type="checkbox"/> M <input checked="" type="checkbox"/> F	87 Yrs.	Months		Days		Hours		Min.		
10a. State		10b. County		10c. City, Town or Location							10d. Inside City Limits	
FL		DADE		MIAMI							<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number		10f. Zip Code							10g. Citizen of What Country?			
7725 SW 86TH STREET, APT. 213		33143							USA			
11. Marital Status		12. Was Decedent Ever in U.S. Armed Forces?			13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)			14. Race - American Indian, Black, White, etc.				
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:			1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			Specify: WHITE				
15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)			16b. Kind of Business/Industry							
Elementary/Secondary (0-12) 12		College (1-4 or 5+) WAITRESS						RESTAURANT				
17. Father's Name (First, Middle, Last)		WEISS			18. Mother's Name (First, Middle, Maiden Surname)							
HARRY					LILLIAN			MORRIS				
19a. Informant's Name/Relationship (Type, Print)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)										
LAWRENCE SILVERBERG / SON		4317 SNOWDROP COURT, ELLICOTT CITY, MD 21042										
20a. Method of Disposition		20b. Place of Disposition (Name of cemetery, cemetery, or other place)			Date		20c. Location - City or Town, State					
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input checked="" type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		LAKESIDE MEMORIAL PARK			04/29/2007		MIAMI, FL					
21. Signature of Funeral Service Licensee		22. Name and Address of Facility			SOL LEVINSON & BROS., INC.							
Matt [Signature]		8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208										
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.		metastatic lung cancer						Approximate Interval Between Onset and Death				
Immediate Cause (Final disease or condition resulting in death)		a. Due to (or as a consequence of): neural effusion										
Sequelae (list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		b. Due to (or as a consequence of): dehydration										
		c. Due to (or as a consequence of): intestinal obstruction										
d. Due to (or as a consequence of):												
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 4 <input type="checkbox"/> Pregnant at time of death 9 <input type="checkbox"/> Unknown			3 <input type="checkbox"/> Ectopic pregnancy 5 <input type="checkbox"/> Other (specify)			23d. Date of delivery Month Day Year				
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Hypertension								23e. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown				
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No										
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)										
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred				
5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined												
28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)								28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.												
29b. Signature and title of certifier Suzan Abdoo MD		29c. License number D50870						29d. Date signed (Month, Day, Year) April 16th 2007				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Suzan Abdoo MD 5005 Signal Bell Lane Clarksville MD 21029		32. Registrar's Signature Suzan Abdoo										
31. Date filed (Month, Day, Year) APR 18 2007												

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division or Vital Records, P.O. Box 68760,
^

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

11

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ar

DHMH 17 Rev 1/2001

**State
registrar**

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

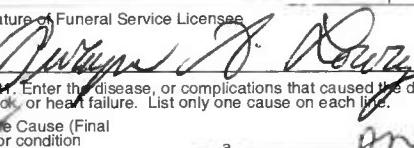
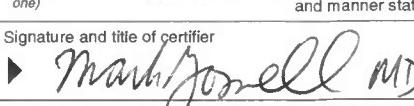
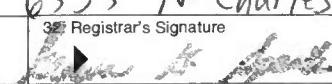
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2007 12408

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) WILMER C. TALLEY				2. Date of Death Month Day Year April 15 2007	3. Time of Death 07:03a M			
	4a. Facility Name (If not institution, give street and number) GREATER BALTIMORE MEDICAL CENTER		4b. City, Town, or Location of Death TOWSON		4c. County of Death BALTIMORE				
Funeral Director	5. Social Security Number 220-07-5423	6. Sex XXM 2□F	7. Age (In yrs. last birthday) 87 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month Day Year) 09/15/1919	9. Birthplace (State or Foreign Country) MARYLAND		
	Usual Residence of Decedent 10a. State MD		10b. County N/A	10c. City, Town or Location BALTIMORE CITY			10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		
To Be Completed by Funeral Director	10e. Street and Number 1416 N. POTOMAC STREET			10f. Zip Code 21213		10g. Citizen of What Country? USA			
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married X Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? US ARMY XX Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates 1943-45		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: BLACK		
Physician /Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11TH			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) CRANE OPERATOR		16b. Kind of Business/Industry BOSTON METAL CORP.			
	17. Father's Name (First, Middle, Last) LINWOOD SAMUEL TALLEY			18. Mother's Name (First, Middle, Maiden Surname) BEATRICE SHIPLEY					
Medical Certification: To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) DARRYL C. TALLEY/GRANDSON			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3226 YOSEMITE AVENUE, BALTIMORE, MD 21215		Date 4/23/07			
	20a. Method of Disposition X Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) MD VETERANS CEM. GARRISON FOREST		20c. Location - City or Town, State OWINGS MILLS, MD			
21. Signature of Funeral Service Licensee 			22. Name and Address of Facility HOWELL FUNERAL HOME 21207 4600 LIBERTY HEIGHTS AVE, BALTIMORE, MD						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)			Approximate Interval Between Onset and Death						
<p>a. Due to (or as a consequence of): pneumonia</p> <p>b. Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. Due to (or as a consequence of):</p>									
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown			23c. If yes, outcome pf pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown					23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. renal failure			23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown						
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide			28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred			
			28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
29b. Signature and title of certifier 			29c. License number D0058082		29d. Date signed (Month, Day, Year) 4/18/07				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mark Gosnell 6535 N Charles St. Suite 550 Towson, MD 21204									
31. Date filed (Month, Day, Year) APR 18 2007			32. Registrar's Signature 						

TALLEY, WILMER
Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene
Certificate of Death

Reg. No.

2007 12409

1 - For State Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) ZEWDE				2. Date of Death Month Day Year ARRIL 16 2007		3. Time of Death 19:45 M	
	4a. Facility Name (If not institution, give street and number) THE JONES HOPKINS HOSPITAL				4b. City, Town, or Location of Death BALTIMORE CITY		4c. County of Death NA	
Funeral Director	5. Social Security Number NA		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 56 Yrs.	If Under 1 Year Months 	If Under 24 Hrs. Days 	8. Date of Birth (Month, Day, Year) 3-19-1951	9. Birthplace (State or Foreign Country) Ethiopia
	Usual Residence of Decedent		10a. State Md		10b. County NA		10c. City, Town or Location Silver Springs	
To Be Completed by Funeral Director	10e. Street and Number 15006 Layhill				10f. Zip Code 20906		10g. Citizen of What Country? Ethiopia	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give 3 <input type="checkbox"/> Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: XX		14. Race - American Indian, Black, White, etc. Ethiopian	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Na		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) NA Housewife		16b. Kind of Business/Industry Home			
	17. Father's Name (First, Middle, Last) Tadesse Kebede				18. Mother's Name (First, Middle, Maiden Surname) Meaza Ayela			
	19a. Informant's Name/Relationship (Type, Print) Ambachew Woreta - Brother				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9233 Winding Way Elliott City, MD 21043			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Emmauel Church Ce		Date 4-21-2007	20c. Location - City or Town, State Addisababa, Ethiopia		
	21. Signature of Funeral Service Licensee ► S lady Wamer		22. Name and Address of Facility March F/H East 1101 E. North Avenue Baltimore, Md 21202					
Physician /Medical Examiner	<p>23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.</p> <p>Immediate Cause (Final disease or condition resulting in death) SEPSIS</p> <p>Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</p> <p>a. Due to (or as a consequence of): CHOLANGIO CARCINOMA</p> <p>b. Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. Due to (or as a consequence of):</p> <p>Approximate Interval Between Onset and Death 4 DAYS</p> <p>2 MONTHS</p>							
Medical Certification: To Be Completed by Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome pf pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify)				23d. Date of delivery Month Day Year	
	<p>Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.</p> <p>23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown</p> <p>24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</p> <p>24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</p>							
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		Hospital: Unpatient		26. Place of Death (Check only one) 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year) 		28b. Time of Injury M	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred	
	5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier ► BHD					
	2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29c. License number RES-000		29d. Date signed (Month, Day, Year) 4-17-2007			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BLISS BENNETT JOHNS HOPKINS HOSPITAL 600 NORTH WOLFE STREET BALTIMORE MD 21287							
State Registrar	31. Date filed (Month, Day, Year) APR 18 2007		32. Registrar's Signature ► [Signature]					

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

2

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

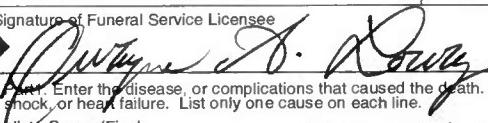
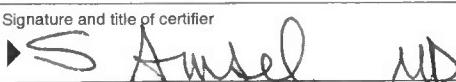
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2007 12410

Reg. No.

1- For State Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) LINA COLEMAN WILLIAMS					2. Date of Death Month Day Year APRIL 13 2007		3. Time of Death 10:32A M			
	4a. Facility Name (If not institution, give street and number) MARYLAND GENERAL HOSPITAL			4b. City, Town, or Location of Death BALTIMORE CITY			4c. County of Death N/A				
Funeral Director	5. Social Security Number 219-12-7238	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 85 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) 01/06/1922	9. Birthplace (State or Foreign Country) VIRGINIA				
To Be Completed by Funeral Director	10a. State MD					10b. County N/A		10c. City, Town or Location BALTIMORE CITY	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
	10e. Street and Number 2130 PARK AVENUE				10f. Zip Code 21217			10g. Citizen of What Country? USA			
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give X Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: BLACK			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) COOK			16b. Kind of Business/Industry FOOD MANAGEMENT				
	17. Father's Name (First, Middle, Last) CHARLES COLEMAN				18. Mother's Name (First, Middle, Maiden Surname) BESSIE WILSON						
	19a. Informant's Name/Relationship (Type, Print) JOYCE TUCK / DAUGHTER			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2130 PARK AVENUE, BALTIMORE, MD 21217							
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) LOUDON PARK CEM.			Date 4/20/07	20c. Location - City or Town, State BALTIMORE, MD			
	21. Signature of Funeral Service Licensee 			22. Name and Address of Facility HOWELL FUNERAL HOME 21207 4600 LIBERTY HEIGHTS AVE, BALTIMORE, MD							
Physician /Medical Examiner	23a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) MYOCARDIAL INFARCTION								Approximate Interval Between Onset and Death 1 MINUTE		
	b. ATHEROSCLEROTIC HEART DISEASE								20 YEARS		
	c. Due to (or as a consequence of):										
	d. Due to (or as a consequence of):										
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome pf pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown						23d. Date of delivery Month Day Year		
Medical Certification: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DIABETES MELLITUS II HYPERTENSION								23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred					
	28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)								
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29c. License number D61437						29d. Date signed (Month, Day, Year) 4/17/07		
	29b. Signature and title of certifier 		29c. License number D61437						29d. Date signed (Month, Day, Year) 4/17/07		
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SAMUEL 1000 CATHEDRAL ST BALTIMORE, MD 21201										
State Registrar	31. Date filed (Month, Day, Year) APR 18 2007		32. Registrar's Signature 								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM 5, per H.C.866, 4/30/07, WS

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2007 12411

1- For
State
Registrar

Physician
/Medical
Examiner

Funeral
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

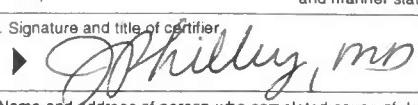
permit Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28e-1 show any injury or other traumatic event, the Medical Examiner must be notified at 910-656-9056.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit

Medical Certification; To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year		3. Time of Death
BETTY ANN BANTUM WRIGHT		April 11 2007		1555 M
4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of Death		4c. County of Death
Sinai Hospital of Baltimore		Baltimore City		N/A
5. Social Security Number	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 52 Yrs.	If Under 1 Year Months Days Hours Min.	8. Date of Birth (Month, Day, Year) AUG 14 1954
217-60-1086 217 04 7042				9. Birthplace (State or Foreign Country) SOUTH CAROLINA
10a. State MARYLAND		10b. County N/A		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
10e. Street and Number 6805 HUNTINGTON DR.		10f. Zip Code 21207		10g. Citizen of What Country? U.S.A.
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: BLACK	14. Race - American Indian, Black, White, etc.	
Elementary/Secondary (0-12) 12th grade	College (1-4 or 5+) 2yrs	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) BILLING REP.	16b. Kind of Business/Industry QUEST DIAGNOSTIC	
17. Father's Name (First, Middle, Last) JAMES GEORGE			18. Mother's Name (First, Middle, Maiden Surname) ETHEL MAE JACOBS	
19a. Informant's Name/Relationship (Type, Print) Cheri Bantum/Daughter		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6805 Huntington Drive, Baltimore, Maryland 21207		
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) WOODLAWN CEMETERY	Date 04-17-07	20c. Location - City or Town, State BALTIMORE, MARYLAND
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility WILLIAM C BROWN COMMUNITY FUNERAL HOME P.A. 1206 W NORTH AVENUE		
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		Approximate Interval Between Onset and Death 1 week		
a. <u>Acute respiratory distress syndrome</u> Due to (or as a consequence of): b. <u>Pneumonia</u> Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____		3 weeks		
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				
23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown				
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier 		
		29c. License number RES-000		29d. Date signed (Month, Day, Year) April 11, 2007
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Julie Philey, MD Sinai Hospital of Baltimore				
31. Date filed (Month, Day, Year) APR 18 2007		32. Registrar's Signature 		

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 12412

1- For State Registrar

Physician /Medical Examiner

Funeral Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760, W.S.

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) Margaret Diane Williamson		2. Date of Death Month Day Year April 14, 2007	3. Time of Death 1:12 P M		
4a. Facility Name (If not institution, give street and number) 5800 Perrylane		4b. City, Town, or Location of Death Suitland			
4c. County of Death Prince George's		4d. Date of Birth (Month, Day, Year) Sept 19, 1954			
5. Social Security Number 578 84 1150		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 52 Yrs.		
8. If Under 1 Year Months Days		9. If Under 24 Hrs. Hours Min.			
10a. State Maryland		10b. County Prince George's			
10c. City, Town or Location Suitland		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
10e. Street and Number 5800 Perrylane		10f. Zip Code 20746	10g. Citizen of What Country? United States		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give X Year or Dates: 12	13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: Dry Cleaners		
14. Race - American Indian, Black, White, etc. Specify: White		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12			
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Dry Cleaners		16b. Kind of Business/Industry Laundry			
17. Father's Name (First, Middle, Last) James Ashley Mattingly		18. Mother's Name (First, Middle, Maiden Surname) Margaret J. Rice			
19a. Informant's Name/Relationship (Type, Print) Julia Todd (Daughter)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2214 Brinkley Road, Fort Washington, MD 20744			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) ► M. D. Davachi 4/10/0152		20b. Place of Disposition (Name of cemetery, crematory or other place) St. Ignatius Church Cemetery	20c. Date April 20, 2007		
21. Signature of Funeral Service License ► M. D. Davachi 4/10/0152		22. Name and Address of Facility Lee Funeral Home, Inc 6633 Old Alexandria Ferry Road, Clinton, MD 20735			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		Approximate Interval Between Onset and Death Adams Car Crash of Rectum with Metal			
<p>a. Due to (or as a consequence of): Adams Car Crash of Rectum with Metal</p> <p>b. Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. _____</p>					
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Unknown	23d. Date of delivery Month Day Year		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29c. License number D25640		29d. Date signed (Month, Day, Year) April 17, 2007	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Davachi 7801 Old Branch Ave #409, Clinton, MD 20735		32. Registrar's Signature ► K. Davachi 4/17/07			
31. Date filed (Month, Day, Year) APR 18 2007		33. Date signed (Month, Day, Year)			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2007 12413

1- For State Registrar

Physician/
Medical ExaminerFuneral
Director

To Be Completed by Funeral Director

Baltimore, MD 21215-0036

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Physician/ Medical Examiner		1. Decedent's Name (First, Middle, Last) Brenda L. Wolf								2. Date of Death Month Day Year April 14, 2007		3. Time of Death 1310 hrs	
Funeral Director		4a. Facility Name (if not institution, give street and number) Baltimore Washington Medical Center				4b. City, Town, or Location of Death Glen Burnie				4c. County of Death Anne Arundel			
		5. Social Security Number 217-04-3752		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 40		Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (MM/DD/YYYY) March 24, 1967	9. Birthplace (State or Foreign Country) MD		
		Usual Residence of Decedent 10a. State MD 10b. County Anne Arundel 10c. City, Town or Location Glen Burnie								10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
		10e. Street and Number 333 Margate Dr				10f. Zip Code 21060				10g. Citizen of What Country? USA			
		11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No specify:			14. Race - American Indian, Black, White, etc. White				
		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker				16b. Kind of Business/Industry Own Home			
		17. Father's Name (First, Middle, Last) Carroll A. Obert				18. Mother's Name (First, Middle, Maiden Surname) Sharon Gail Hammett							
		19a. Informant's Name/Relationship (Type, Print) Carroll A. Obert Father				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1004 7th St, Glen Burnie, MD 21060							
		20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other Specify K. Gregor Fink M01148				20b. Place of Disposition (Name of cemetery, crematory or other place) Crestlawn Cemetery				Date Apr 19, 2007	20c. Location - City or Town, State Marriotsville, MD		
		21. Signature of Funeral Service Licensee K. Gregor Fink				22. Name and Address of Facility Fink Funeral Home, P.A. 426 Crain Hwy S, Glen Burnie, MD 21061							
Physician /Medical Examiner		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.										Approximate Interval Between Onset and Death	
		a. Hypertensive heart disease Due to (or as a consequence of):											
		b. Due to (or as a consequence of):											
		c. Due to (or as a consequence of):											
		d. Due to (or as a consequence of):											
		<input checked="" type="checkbox"/> UNPENDED		<input type="checkbox"/> AMENDED #23a, PII, 27, per ME, g867, 5/15/07 TT									
		IF FEMALE: 23b. Was decedent pregnant in the past 12 months?		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown				23d. Date of delivery Month Day Year					
		<input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Unknown											
		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
		Asthma										24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
		25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26 Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other:									
		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury		28c. Injury at Work?		28d. Describe how injury occurred			
								<input type="checkbox"/> Yes <input type="checkbox"/> No					
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State)			
		29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.											
		29b. Signature and title of certifier Patricia Aronica-Pollak		29c. License number O.C.M.E.				29d. Date signed (Month, Day, Year) April 15, 2007					
		30. Name and address of person who completed cause of death (Item 23a) Patricia Aronica-Pollak MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201											
		31. Date filed (Month, Day, Year) APR 18 2007		32. Registrar's Signature [Signature]									

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 12411

1 - For State Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>Samuel Welling</i>				2. Date of Death Month April Day 12 Year 2007		3. Time of Death 2:45A M
	4a. Facility Name (If not institution, give street and number) <i>The Johns Hopkins Hospital</i>				4b. City, Town, or Location of Death <i>Baltimore</i>		4c. County of Death
Funeral Director	5. Social Security Number <i>217-71-4821</i>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <i>2 Yrs.</i>	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <i>Dec. 29, 2004</i>	9. Birthplace (State or Foreign Country) <i>Maryland</i>
	Usual Residence of Decedent 10a. State <i>Maryland</i>				10b. County <i>Harford</i>		10c. City, Town or Location <i>Bel Air</i>
To Be Completed by Funeral Director	10e. Street and Number <i>1905 Wagner Farm Road</i>				10f. Zip Code <i>21015</i>		10g. Citizen of What Country? <i>USA</i>
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: <i>If Yes, Give Year or Dates:</i>			13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: <i>White</i>			14. Race - American Indian, Black, White, etc. Specify: <i>White</i>
15. Decedent's Education (Specify only highest grade completed) <i>Elementary/Secondary (0-12) 0</i>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Never Worked</i>			16b. Kind of Business/Industry
17. Father's Name (First, Middle, Last) <i>Scott David Welling</i>				18. Mother's Name (First, Middle, Maiden Surname) <i>Amanda Lynn Bates</i>			
19a. Informant's Name/Relationship (Type, Print) <i>Scott David Welling/ Father</i>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>1905 Wagner Farm Road, Bel Air, Maryland 21015</i>			
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <i>Hilltop Service Corp.</i>				20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Hilltop Service Corp.</i>	Date <i>4-13-07</i>	20c. Location - City or Town, State <i>Towson, Maryland</i>	
21. Signature - Funeral Service Licensee <i>Charles A. Engle</i>				22. Name and Address of Facility <i>McComas Funeral Home, P.A. 1317 Cokesbury Rd., Abingdon, Maryland 21009</i>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <i>pneumonia</i>							
Approximate Interval Between Onset and Death <i>9 days</i>							
23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown				23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>seizure disorder undiagnosed genetic disorder</i>							
23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown							
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide				28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred
28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) manner stated.							
29b. Signature and title of certifier <i>Carolyn M. Feltz MD</i>				29c. License number <i>Res- 000</i>		29d. Date signed (Month, Day, Year) <i>April 12, 2007</i>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Carolyn M. Feltz MD 600 N. Wolfe St Baltimore MD 21287</i>							
31. Date filed (Month, Day, Year) <i>APR 18 2007</i>		32. Registrar's Signature <i>James M. Feltz</i>					

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division or Vital Records, P.O. Box 68760, US

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.	
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	
Within 24 hours after death.	
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.	
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	
Within 24 hours after death.	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 12615

1- For State Registrar

Physician /Medical Examiner

Funeral Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed

within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year				3. Time of Death
Robert J. Ward	April 14, 2007				2:30 PM
4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death				
Knollwood Manor Nursing Home	Millersville				Anne Arundel
5. Social Security Number	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 218-40-1190 63 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) July 10 1943 Maryland
10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Maryland	Anne Arundel	Orchard Beach			
10e. Street and Number	10f. Zip Code			10g. Citizen of What Country?	
1106 Beach Promenade Apt. 1B	21226			U.S.A.	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	14. Race - American Indian, Black, White, etc. Specify: White		
Elementary/Secondary (0-12) 12	College (1-4 or 5+) N/A	15. Decedent's Education (Specify only highest grade completed)	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Self Employed	16b. Kind of Business/Industry Salesman	
17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)				
John G. Ward	Eva E. Sipes				
19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)				
Kimberly A. Ward (Daughter)	216 Falcon Drive, Pasadena, Maryland 21122				
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State Baltimore, Maryland		
21. Signature of Funeral Service Licensee 	22. Name and Address of Facility McCully-Polyniak Funeral Home P.A. 3204 Mountain Road, Pasadena, Maryland 21122				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)	Approximate Interval Between Onset and Death YEARS				
a. <i>ATHEROSCLEROTIC CARDIOVASCULAR DISEASE</i> Due to (or as a consequence of):					
b. Due to (or as a consequence of):					
c. Due to (or as a consequence of):					
d. Due to (or as a consequence of):					
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	23c. If yes, outcome pf pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown <input type="checkbox"/> Other (specify) _____	23d. Date of delivery Month Day Year			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown
					24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
					24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred	
	M				
29a. Certifier (Check only one) <input type="checkbox"/> Medical Examiner	28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)				
29b. Signature and title of certifier 	29c. License number D31136			29d. Date signed (Month, Day, Year) APRIL 17, 2007	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)					
31. Date filed (Month, Day, Year) APR 18 2007	32. Registrar's Signature 				

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 200712416

Physician /Medical Examiner		1. Decedent's Name (First, Middle, Last) Benjamin Staud Walker, Sr.						2. Date of Death Month Day Year April 14, 2007		3. Time of Death 10:24 P M				
Funeral Director		4a. Facility Name (If not institution, give street and number) Suburban Hospital			4b. City, Town, or Location of Death Bethesda			4c. County of Death Montgomery						
To Be Completed by Funeral Director		5. Social Security Number 577-36-9062		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 77 Yrs.		If Under 1 Year Months	If Under 24 Hrs. Days	Hours	Min.	8. Date of Birth (Month, Day, Year) Jan. 29, 1930		9. Birthplace (State or Foreign Country) Nebraska	
		Usual Residence of Decedent										10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
		10a. State Maryland		10b. County Montgomery		10c. City, Town or Location Rockville						10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
		10e. Street and Number 11317 Marcliff Road				10f. Zip Code 20852				10g. Citizen of What Country? United States				
		11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: Korea		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: White				14. Race - American Indian, Black, White, etc. Specify: White				
		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 5+ Writer		16b. Kind of Business/Industry Public Relations								
		17. Father's Name (First, Middle, Last) Benjamin Franklin Staud						18. Mother's Name (First, Middle, Maiden Surname) Janet Powell						
		19a. Informant's Name/Relationship (Type, Print) Constance C. Walker/Wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11317 Marcliff Road, Rockville, Maryland 20852								
		20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) Ray Staud				20b. Place of Disposition (Name of cemetery, crematory or other place) Montgomery Crematorium, Inc.				Date April 17, 2007		20c. Location - City or Town, State Bethesda, Maryland		
		21. Signature of Funeral Service Licensee Robert A. Pumphrey Funeral Home/Chase, Inc.						22. Name and Address of Facility M00198 7557 Wisconsin Ave., Bethesda, MD 20814-3501						
		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. First listing is Primary Cause (Disease or injury that initiated events resulting in death) Last												
		23b. Due to (or as a consequence of): Subdural Hematoma Approximate Interval Between Onset and Death 17 days mild m/s 3/29/07 4/17/07												
		23c. If yes, outcome pf pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown												
		23d. Date of delivery Month Day Year												
		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Prostate Cancer												
		23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown												
		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No												
		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No												
		25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No												
		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) Evening M												
		27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide												
		28a. Date of Injury (Month, Day Year) 3/29/07												
		28b. Time of Injury Evening M												
		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No												
		28d. Describe how injury occurred Fall From Standing												
		28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Home												
		28f. Location (Street and Number or Rural Route Number, City or Town, State) 11317 Marcliff Rd. Rockville, Maryland												
		29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.												
		29b. Signature and title of certifier Nelson Kalil, M.D.												
		29c. License number D51616												
		29d. Date signed (Month, Day, Year) April 16, 2007												
		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Nelson Kalil, M.D. 5454 Wisconsin Avenue #1300, Chevy Chase, Maryland 20815												
State Registrar		31. Date filed (Month, Day, Year) APR 18 2007		32. Registrar's Signature Ben F. Smith										

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filed in by the funeral director, page 2 should be detached for use as the burial/transit

Division or Vital Records, P.O. Box 68760,

div

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

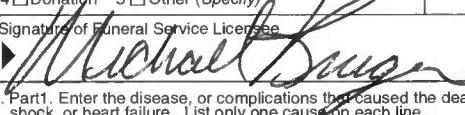
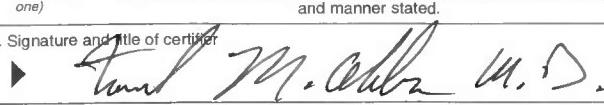
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2007 12417

1- For State Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) ARLENE WEINER						2. Date of Death Month APRIL Day 14 Year 2007	3. Time of Death 9:50P M
	4a. Facility Name (If not institution, give street and number) 2702 JEREMY COURT APT. - D			4b. City, Town, or Location of Death BALTIMORE			4c. County of Death N/A	
Funeral Director	5. Social Security Number 219-38-5317	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 66 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) 05/17/1940	9. Birthplace (State or Foreign Country) MD	
	Usual Residence of Decedent 10a. State MD 10b. County N/A			10c. City, Town or Location BALTIMORE				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
To Be Completed by Funeral Director	10e. Street and Number 2702 JEREMY COURT APT. - D			10f. Zip Code 21209			10g. Citizen of What Country? U.S.A.	
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: Specify: WHITE			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) ADMINISTRATOR			16b. Kind of Business/Industry PRINTING	
	17. Father's Name (First, Middle, Last) LEON ROMM			18. Mother's Name (First, Middle, Maiden Surname) ESTHER GLASER				
	19a. Informant's Name/Relationship (Type, Print) ARTHUR ROMM / BROTHER			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8002 VALLEY MANOR ROAD - OWINGS MILLS, MD 21117				
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) OHEB SHALOM MEMORIAL PARK			Date 04/17/2007	
	21. Signature of Funeral Service Licensee 			22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208			20c. Location - City or Town, State REISTERSTOWN, MD.	
Physician /Medical Examiner	<p>23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.</p> <p>Immediate Cause (Final disease or condition resulting in death)</p> <p>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</p> <p>a. Due to (or as a consequence of): Primary Peritoneal Cancer</p> <p>b. Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. Due to (or as a consequence of):</p> <p>Approximate Interval Between Onset and Death</p>							
Medical Certification: To Be Completed by Physician/Medical Examiner	<p>IF FEMALE:</p> <p>23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown</p> <p>23c. If yes, outcome pf pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown <input type="checkbox"/> Other (specify) _____</p> <p>23d. Date of delivery Month Day Year</p>							
	<p>Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.</p> <p>23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown</p>							
	<p>24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>							
	<p>25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)</p>							
	<p>26. Place of Death (Check only one)</p> <p>27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide</p> <p>28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>28d. Describe how injury occurred</p> <p>28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)</p> <p>28f. Location (Street and Number or Rural Route Number, City or Town, State)</p>							
	<p>29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.</p> <p>29b. Signature and title of certifier </p> <p>29c. License number D38972</p> <p>29d. Date signed (Month, Day, Year) 4/16/07</p>							
	<p>30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2411 W. Belvedere Ave MD 21206 Baltimore MD 21215 Fouad Abbes MD</p>							
State Registrar	31. Date filed (Month, Day, Year) APR 18 2007		32. Registrar's Signature 					

Division or Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

10

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend items 10b,c,e,f per fh g869 7-11-07 vt

State of Maryland / Department of Health and Mental Hygiene

1- For State amend #5 Per FH G880 6/04/08 Certificate of Death

Reg. No.

2007 12418

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Joseph Arthur Yager Jr.					2. Date of Death Month Day Year April 5, 2007	3. Time of Death M 6:30A
	4a. Facility Name (If not institution, give street and number) Doctor's Community Hospital			4b. City, Town, or Location of Death New Carrollton		4c. County of Death Prince George's	
Funeral Director	5. Social Security Number 370-18-2181	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 90 Yrs.	If Under 1 Year Months Days Hours Min.	8. Date of Birth (Month, Day, Year) 04/14/1916	9. Birthplace (State or Foreign Country) IN	
To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State MD 10b. County Montgomery 10c. City, Town or Location Bethesda					10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	10e. Street and Number 10450 Lottsford Rd. Apt. 5109					10f. Zip Code 20817	10g. Citizen of What Country? USA
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Caucasian	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Research Analyst		16b. Kind of Business/Industry Government		
	17. Father's Name (First, Middle, Last) Joseph Arthur Yager					18. Mother's Name (First, Middle, Maiden Surname) Edna Gertrude Pratt	
	19a. Informant's Name/Relationship (Type, Print) George Holborow/Buyer			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4301 Jones Bridge Rd. Bethesda, MD 20814-			
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) USUHS		Date Apr 5 2007	20c. Location - City or Town, State Bethesda, MD	
	21. Signature of Funeral Service Licensee Linda Sue Ritter Molay					22. Name and Address of Facility Rapp Funeral & Cremation Services 933 Gist Ave. Silver Spring, Maryland 20910-	
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)					Approximate Interval Between Onset and Death 5 days	
	a. Hypoxic encephalopathy Due to (or as a consequence of):						
	b. Aspiration Pneumonia Due to (or as a consequence of):					1 week.	
	c. Dysphagia Due to (or as a consequence of):					~ 3 weeks	
	d. Cardiac arrest, twice					5 days	
Medical Certification: To Be Completed by Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome pf pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown <input type="checkbox"/> Other (Specify)		23d. Date of delivery Month Day Year		
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Acute renal failure Septicemia, MRSA Coronary Artery Disease					23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		23f. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)	28b. Time of Injury M 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred		
	5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					29b. Signature and title of certifier Alain G. CHAMPALOUX MD	29c. License number D042049
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Alain G. CHAMPALOUX MD - Upper Marlboro - MD - 20772					29d. Date signed (Month, Day, Year) April 5th, 2007	
State Registrar	31. Date filed (Month, Day, Year) APR 18 2007		32. Registrar's Signature Alain G. CHAMPALOUX		33. Date issued (Month, Day, Year)		

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

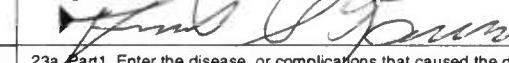
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2007 12419

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) THELMA M. ZEPP							2. Date of Death Month: April Day: 17 Year: 2007	3. Time of Death 10:55A ^M
	4a. Facility Name (If not institution, give street and number) Charlestown			4b. City, Town, or Location of Death Catonsville			4c. County of Death Baltimore		
Funeral Director	5. Social Security Number 215-05-2792	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 91 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) May 30, 1915	9. Birthplace (State or Foreign Country) Maryland		
To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State Maryland			10b. County Baltimore			10c. City, Town or Location Catonsville	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	10e. Street and Number 715 Maiden Choice Lane			10f. Zip Code 21228			10g. Citizen of What Country? U.S.A.		
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: 8		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Cashier			16b. Kind of Business/Industry Motor Vehicles Admin.		
	17. Father's Name (First, Middle, Last) William Zang				18. Mother's Name (First, Middle, Maiden Surname) Sophia Etzel				
	19a. Informant's Name/Relationship (Type, Print) Charles W. Zepp (Son)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2723 Mystic Woods Court, Mt. Airy, Maryland 21771				
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Holy Cross Cemetery		Date 04-20-07	20c. Location - City or Town, State Baltimore, Maryland		
Physician /Medical Examiner	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility McCully-Polyniak Funeral Home P.A. 130 E. Fort Avenue, Baltimore, Maryland 21230				
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)					Approximate Interval Between Onset and Death			
	a. Due to (or as a consequence of) Sepsis								
	b. Due to (or as a consequence of) Stroke								
	c. Due to (or as a consequence of): 								
	d. 								
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year			
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
								24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide				28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred
					28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
	29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29c. License number D47009				
					29d. Date signed (Month, Day, Year) April 17, 2007				
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Phillip Stone, 711 Maiden Choice Lane, Baltimore, MD 21228								
	31. Date filed (Month, Day, Year) APR 18 2007		32. Registrar's Signature 						

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or items 23a or 28e-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

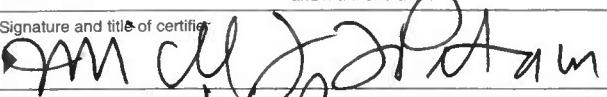
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2007 12120

1- For State Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) HOWARD B ARRINGTON				2. Date of Death Month 03 Day 24 Year 07		3. Time of Death 1703	
	4a. Facility Name (If not institution, give street and number) Anne Arundel Medical Center				4b. City, Town, or Location of Death Annapolis		4c. County of Death Anne Arundel	
Funeral Director	5. Social Security Number 579-28-6265	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 79 Yrs.	If Under 1 Year Months 0	If Under 24 Hrs. Days 0	8. Date of Birth (Month Day Year) 6/27/1927	9. Birthplace (State or Foreign Country) Virginia	
To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State MD 10b. County Anne Arundel 10c. City, Town or Location Edgewater 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
	10e. Street and Number 3710 Fifth Ave.			10f. Zip Code 21037		10g. Citizen of What Country? USA		
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No 1944-1946 If Yes, Give Year or Dates: 1946		13. Was Decedent of Hispanic Origin? (Specify Yes or No) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. White		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Plumber		16b. Kind of Business/Industry Federal Government			
	17. Father's Name (First, Middle, Last) Charles Daniel Arrington				18. Mother's Name (First, Middle, Maiden Surname) Lillie Octavia Carter			
	19a. Informant's Name/Relationship (Type, Print) Margaret Arrington Wife			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3710 Fifth Ave. Edgewater, MD 21037				
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Lakemont Cemetery		Date 3/28/2007	20c. Location - City or Town, State Davidsonville, MD		
	21. Signature of Funeral Service Licensee 			22. Name and Address of Facility Hardesty Funeral Home, P.A. 12 Ridgely Ave. Annapolis, MD 21401				
Physician /Medical Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Glio BLASTOMA MULTIFORME Approximate Interval Between Onset and Death 5D							
	23b. Part 2. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Chronic myelogenous leukemia							
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome pf pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown <input type="checkbox"/> Other (Specify)		23d. Date of delivery Month Day Year			
Medical Certification: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Chronic myelogenous leukemia							
	23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown							
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred		
			28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29c. License number D 21438					
	29b. Signature and title of certifier  MICHAEL J. LAFON		29d. Date signed (Month, Day, Year) March 24 2007					
State Registrar	31. Date filed (Month, Day, Year) MAR 26 2007		32. Registrar's Signature 					

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

15+1
State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2007 12421

1- For
State
Registrar

Physician
/Medical
Examiner

Baltimore, Maryland 21215-0036
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.

To Be Completed by Funeral Director

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year				3. Time of Death
Paul D. Anderson Jr.				April 4, 2007	1:55 p.m.
4a. Facility Name (If not institution, give street and number) 3637 Ligon Rd.			4b. City, Town, or Location of Death Ellicott City		4c. County of Death Howard
5. Social Security Number 216 72 3677		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 46 Yrs.	If Under 1 Year Months Days Hours Min.	8. Date of Birth (Month, Day, Year) May 10, 1960
9. Birthplace (State or Foreign Country) Maryland					
10a. State Md.		10b. County Howard		10c. City, Town or Location Ellicott City	
10e. Street and Number 3637 Ligon Rd.			10f. Zip Code 21042		10g. Citizen of What Country? USA
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: Specify: White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Manager		16b. Kind of Business/Industry United Stationers	
17. Father's Name (First, Middle, Last) Paul D. Anderson			18. Mother's Name (First, Middle, Maiden Surname) Helen Thurman		
19a. Informant's Name/Relationship (Type, Print) Helen T. Anderson/Mother			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3637 Ligon Road Ellicott City, Maryland 21042		
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Crest Lawn Memorial		Date 4-11-2007	20c. Location - City or Town, State Marriottsville, Md.
21. Signature of Funeral Service Licensee ► Helen Ollis-Wright			22. Name and Address of Facility Harry H. Witzke's Family F.H. Inc. 4112 Old Columbia Pike Ellicott City, Md. 21043		

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year	
23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown							
23f. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No			
25. Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA		26. Place of Death (Check only one) Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier ► L. Austin Doyle, MD		29c. License number D23809		29d. Date signed (Month, Day, Year) April 5, 2007	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) L. Austin Doyle, MD, Greenbaum Cancer Ctr., 22 S. Greene St., Baltimore, MD 21201		31. Date filed (Month, Day, Year) APR 05 2007		32. Registrar's Signature Karen A. Speer			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2007 12422
Reg. No.

1- For State Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) THOMAS LEE ADAMS				2. Date of Death Month March Day 31, Year 2007	3. Time of Death M 1602 M		
	4a. Facility Name (If not institution, give street and number) Coastal Hospice at the Lake		4b. City, Town, or Location of Death Salisbury		4c. County of Death Wicomico			
Funeral Director	5. Social Security Number 218-16-5617	6. Sex XXM 2 F	7. Age (In yrs. last birthday) 83 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Sept. 8, 1923	9. Birthplace (State or Foreign Country) Maryland	
	Usual Residence of Decedent 10a. State Maryland		10b. County Somerset		10c. City, Town or Location Crisfield		10d. Inside City Limits 1 Yes 2 No	
To Be Completed by Funeral Director	10e. Street and Number 4 Hudson Street			10f. Zip Code 21817		10g. Citizen of What Country? USA		
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: 1923		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: White		14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Mechanic		16b. Kind of Business/Industry Paintbrush Manufacturer			
	17. Father's Name (First, Middle, Last) John T. Adams			18. Mother's Name (First, Middle, Maiden Surname) Lottie Green				
	19a. Informant's Name/Relationship (Type, Print) Brenda M. Tull (Daughter)			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3 Hudson Street - Crisfield, MD 21817				
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) Mary Beth Bradshaw-Pruitt		20b. Place of Disposition (Name of cemetery, crematory or other place) Sunnyridge Memorial Park		Date April 4, 2007	20c. Location - City or Town, State Crisfield, Maryland		
Physician /Medical Examiner	21. Signature of Funeral Service Licensee Mary Beth Bradshaw-Pruitt		22. Name and Address of Facility Bradshaw & Sons Funeral Home 306 W. Main Street - Crisfield, MD 21817					
To Be Completed by Physician/Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) End Stage Renal Disease							
	Approximate Interval Between Onset and Death							
	23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown							
	23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown							
	23d. Date of delivery Month Day Year							
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
	23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown							
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No							
	24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No							
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No							
	26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide							
	28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No							
	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No							
	28d. Describe how injury occurred							
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)							
	28f. Location (Street and Number or Rural Route Number, City or Town, State)							
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
	29b. Signature and title of certifier David Cowall							
	29c. License number D26278							
	29d. Date signed (Month, Day, Year) 4-5-07							
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) David Cowall, MD Coastal Hospice, PO Box 1773 Salisbury, MD 21802							
State Registrar	31. Date filed (Month, Day, Year) APR 06 2007		32. Registrar's Signature Bev G. Spangler					

Baltimore, Maryland 21215-0036

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene
Certificate of Death

2007 12423

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) THELMA DOROTHY BARLOW							2. Date of Death Month Day Year MARCH 31 2007	3. Time of Death 8:30 AM	
	4a. Facility Name (If not institution, give street and number) 2957 SOUTHAVEN DRIVE			4b. City, Town, or Location of Death ANNAPOLIS			4c. County of Death ANNE ARUNDEL			
Funeral Director	5. Social Security Number 032 01 9213		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 87 Yrs.	If Under 1 Year Months Days Hours Min. 	8. Date of Birth (Month, Day, Year) 01/08/1920	9. Birthplace (State or Foreign Country) Massachusetts			
	10a. State MD		10b. County ANNE ARUNDEL		10c. City, Town or Location ANNAPOLIS			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
To Be Completed by Funeral Director	10e. Street and Number 2957 SOUTHAVEN DRIVE				10f. Zip Code 21401		10g. Citizen of What Country? USA			
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: 		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: 			14. Race - American Indian, Black, White, etc. Specify: White		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) HOMEMAKER			16b. Kind of Business/Industry OWN HOME			
	17. Father's Name (First, Middle, Last) STANLEY EDWARD MACMASTER				18. Mother's Name (First, Middle, Maiden Surname) IDA MAE MACKEY					
Physician /Medical Examiner	19a. Informant's Name/Relationship (Type, Print) CRAIG BARLOW (SON)			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2957 SOUTHAVEN DRIVE, ANNAPOLIS MD 21401						
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <i>Melanie Willard</i>			20b. Place of Disposition (Name of cemetery, crematory or other place) Metropolitan Crematory			Date 4/2/07	20c. Location - City or Town, State Alexandria VA		
	21. Signature of Funeral Service Licensee <i>Melanie Willard</i>			22. Name and Address of Facility ADVENT FUNERAL AND CREMATION SERVICES ANNAPOLIS AND FALLS CHURCH						
	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) 			Approximate Interval Between Onset and Death 10 years						
	23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown			23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____			23d. Date of delivery Month Day Year			
	23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						
	23f. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 			24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No						
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) _____						
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide			28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred		
	28d. Describe how injury occurred			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.			29c. License number J 0636371						
	29b. Signature and title of certifier <i>Raymond Banfield</i>			29d. Date signed (Month, Day, Year) 4/2/2007						
State Registrar	30. Name and address of person who completed use of death (Item 23a) (Type, Print) 3169 BRANFERTON ST # 201 Edgewater, MD 21037			32. Registrar's Signature <i>Raymond Banfield</i>						
	31. Date filed (Month, Day, Year) APR 03 2007			32. Registrar's Signature <i>Raymond Banfield</i>						

Baltimore, Maryland 21215-0036

Permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached or used as the burial/transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 12626

1 - For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Maureen Clare Bauer					2. Date of Death Month March	Day 30	Year 2007	3. Time of Death 5:15 AM		
	4a. Facility Name (If not institution, give street and number) Mandrin Hospice House					4b. City, Town, or Location of Death Harwood		4c. County of Death Anne Arundel			
Funeral Director	5. Social Security Number 193-40-3255	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 57 Yrs.	If Under 1 Year Months 0	If Under 24 Hrs. Hours 0	8. Date of Birth (Month, Day, Year) April 3, 1949	9. Birthplace (State or Foreign Country) Pennsylvania				
	Usual Residence of Decedent 10a. State Maryland					10b. County Anne Arundel		10c. City, Town or Location Annapolis			
To Be Completed by Funeral Director	10e. Street and Number 1615 Elkwood Court					10f. Zip Code 21409		10g. Citizen of What Country? U.S.A.			
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: 2			13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: White			14. Race - American Indian, Black, White, etc. Specify: White			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Computer Analyst			16b. Kind of Business/Industry Utilities				
	17. Father's Name (First, Middle, Last) Edward Hargadon					18. Mother's Name (First, Middle, Maiden Surname) Mary Clare Wilkinson					
	19a. Informant's Name/Relationship (Type, Print) Meghan Bauer/daughter			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1615 Elkwood Court Annapolis, Maryland 21409							
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) Baltimore Crematory			20b. Place of Disposition (Name of cemetery, crematory or other place) Baltimore Crematory			Date 4/3/2007	20c. Location - City or Town, State Baltimore, Maryland			
Physician /Medical Examiner	21. Signature of Funeral Service Licensee Todd E. Miller			22. Name and Address of Facility John M. Taylor Funeral Home 147 Duke of Gloucester St., Annapolis, MD 21401							
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Rectal cancer					Approximate Interval Between Onset and Death 2-3 years					
	<p>a. Due to (or as a consequence of): Rectal cancer</p> <p>b. Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. Due to (or as a consequence of):</p>										
	23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown			23c. If yes, outcome pf pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown <input type="checkbox"/> Other (specify) _____			23d. Date of delivery Month 0			Year 2007	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown					
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospice House							
				Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA			Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify)				
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide			28a. Date of Injury (Month, Day Year) 28b. Time of Injury M			28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			28d. Describe how injury occurred	
				28e. Place of injury : At home, farm, street, factory, office building, etc. (Specify) At home						28f. Location (Street and Number or Rural Route Number, City or Town, State)	
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
	29b. Signature and title of certifier Jeanine Werner MD			29c. License number DS2830			29d. Date signed (Month, Day, Year) March 30, 2007				
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jeanine Werner, MD 900 Beskate Road #300, Annapolis, MD 21401										
State Registrar	31. Date filed (Month, Day, Year) APR 02 2007			32. Registrar's Signature Jeanine Werner							

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

certificate.

W
State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2007 12425

1- For State Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) I Luminado D. Bondoc				2. Date of Death Month 3 Day 28 Year 2007	3. Time of Death 3:48 AM	
	4a. Facility Name (If not institution, give street and number) ANNE ARUNDEL MEDICAL CENTER				4b. City, Town, or Location of Death ANNAPOLIS		4c. County of Death ANNE ARUNDEL
Funeral Director	5. Social Security Number 509-04-1229	6. Sex 1 M 2 F	7. Age (In yrs. last birthday) 78 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) DECEMBER 6, 1928	9. Birthplace (State or Foreign Country) PHILIPPINES
	Usual Residence of Decedent MARYLAND ANNE ARUNDEL				10c. City, Town or Location GAMBRILLS		
To Be Completed by Funeral Director	10e. Street and Number 1084 SNOW HILL LANE				10f. Zip Code 21054	10g. Citizen of What Country? UNITED STATES	
	11. Marital Status 1 Never Married 2 Married	12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No Specify:			14. Race - American Indian, Black, White, etc. Specify: FILIPINO
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) HOUSEKEEPER		16b. Kind of Business/Industry HOTEL AND CASINO			
	17. Father's Name (First, Middle, Last) ADRIANO BONDOC				18. Mother's Name (First, Middle, Maiden Surname) TEODORA DIAZ		
	19a. Informant's Name/Relationship (Type, Print) CORAZON A. BONDOC/WIFE				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1084 SNOW HILL LANE, GAMBRILLS, MARYLAND 21054		
	20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State		20b. Place of Disposition (Name of cemetery, crematory or other place) ETERNAL PEACE		Date APRIL 5, 2007	20c. Location - City or Town, State MABALACAT, PAMPANGA, PHILIPPINES	
	21. Signature of Funeral Service Licensee Will E. Bondoc Jr. M00672				22. Name and Address of Facility FELLOWS, HELFENBEIN AND NEWNAM CREMATION AND FUNERAL CARE, P.A. 814 BESTGATE ROAD, ANNAPOLIS, MARYLAND 21401		
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to final cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last						
Medical Certification: To Be Completed by Physician/Medical Examiner	<p>a. Due to (or as a consequence of): Exsanguination</p> <p>b. Due to (or as a consequence of): Epistaxis</p> <p>c. Due to (or as a consequence of): over-anticoagulation.</p> <p>d.</p>						
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown		23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown			23d. Date of delivery Month Day Year	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Atrial Fibrillation						
	23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown						
	25. Was case referred to medical examiner? 1 Yes 2 No		26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)				
	27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide		28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work? M 1 Yes 2 No	28d. Describe how injury occurred	
	5 Pending investigation 6 Could not be determined		28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.						
	29b. Signature and title of certifier Dr. Ian Shantz MD				29c. License number D36203	29d. Date signed (Month, Day, Year) 3-28-2007	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Ian Shantz 2401 Brandonville Blvd Ste 250 Gambrills, MD 21054						
State Registrar	31. Date filed (Month, Day, Year) APR 02 2007		32. Registrar's Signature Leanne B. Geiger				

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2007 12426

**Physician/
Medical Examiner**

**Funeral
Director**

To Be Completed by Funeral Director

Baltimore, MD 21215-0036

Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

1. For State
Registrar

1. Decedent's Name (First, Middle, Last)

Howard Brown

4a. Facility Name (if not institution, give street and number)

St. Thomas More Nursing Home

2. Date of Death

Month Day Year
March 28, 2007

3. Time of Death
1410 hrs

5. Social Security Number

577-12-3109

6. Sex

1 M 2 F

7. Age (In yrs. last birthday)

93 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (MM/DD/YYYY)

04/20/1913

9. Birthplace (State or
Foreign)

South Carolina

Usual Residence of Decedent

10a. State

DC

10b. County

10c. City, Town or Location

Washington

10d. Inside City Limits

1 Yes 2 No

10e. Street and Number

3045 Clinton St., NE

10f. Zip Code

20018

10g. Citizen of What Country?

United States

11. Marital Status

1 Never Married

2 Married

3 Widowed

4 Divorced

12. Was Decedent Ever in U.S.
Armed Forces?

1 Yes 2 No

If Yes, Give Year
or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 Yes 2 No specify:

14. Race - American Indian, Black,
White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

6th

16a. Decedent's Usual Occupation (Give kind of work done
during most of working life. DO NOT use retired)

Wash. Gas Co.

16b. Kind of Business/Industry

Private

17. Father's Name (First, Middle, Last)

Thomas Brown

18. Mother's Name (First, Middle, Maiden Surname)

Charlotte Price

20784

19a. Informant's Name/Relationship (Type, Print)

Adrienne Brown/Granddaughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3813 - 64th Ave., #202, Landover Hills, MD

20a. Method of Disposition

1 Burial

2 Cremation

3 Removal from State

4 Donation

5 Other Specify

20b. Place of Disposition (Name of cemetery,
crematory or other place)

Ft. Lincoln Cemetery

Date

4/6/2007

20c. Location - City or Town, State

Brentwood, MD

21. Signature of Funeral Service Licensee

John T. Stewart, III

22. Name and Address of Facility

Stewart Funeral Home

4001 Benning Rd., NE Wash., DC 20019

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Head Injuries with Complications

Due to (or as a consequence of):

Approximate Interval
Between Onset and
Death

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. _____

Due to (or as a consequence of):

c. _____

Due to (or as a consequence of):

d. _____

UNPENDED

AMENDED

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 9 Unknown

23c. If yes, outcome of pregnancy

1 Live birth

2 Fetal death

3 Ectopic pregnancy

4 Pregnant at time of death

5 Other (Specify)

9 Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 Yes 2 No 3 Probably 4 Unknown

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 12127

3. Time of Death M

1- For
State
RegistrarPhysician
/Medical
ExaminerFuneral
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
 Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

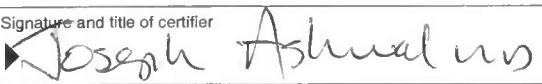
1. Decedent's Name (First, Middle, Last)	Margo Baxter		2. Date of Death Month 03 Day 28 Year 2007	3. Time of Death M
Johns Hopkins Bayview Medical Center Baltimore		4c. County of Death		
5. Social Security Number	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 68 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Hours Min.
228504673				
Usual Residence of Decedent		8. Date of Birth (Month, Day, Year) 08 26 1938		
10a. State VA	10b. County Fairfax	10c. City, Town or Location Alexandria		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
10e. Street and Number 2302 Mary Baldwin Dr. 22307		10f. Zip Code		10g. Citizen of What Country? USA
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	14. Race - American Indian, Black, White, etc. Specify: Black	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker	16b. Kind of Business/Industry Home		
17. Father's Name (First, Middle, Last) Charles Freeman		18. Mother's Name (First, Middle, Maiden Surname) Genevieve Quarles		
19a. Informant's Name/Relationship (Type, Print) Daniella Gilliam/Daughter		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8154 Cobble Pond Way, Manassas VA 20111		
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Arlington National Cemetery	Date 4-11-2007	20c. Location - City or Town, State Arlington, VA
21. Signature of Funeral Service Licensee Rough Wilson		22. Name and Address of Facility Greene Funeral Home 814 Franklin St. Alexandria VA 22314		
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (First disease or condition resulting in death) a. Small Bowel Obstruction Due to (or as a consequence of): b. Aspiration Pneumonia Due to (or as a consequence of): c. Sepsis Due to (or as a consequence of): d.				
Approximate Interval Between Onset and Death 1 month 1 week 1 week				
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Unknown		23c. If yes, outcome pf pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____		23d. Date of delivery Month Day Year
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				
23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown				
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death Check all that apply Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No
		28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29b. Signature and title of certifier Jacqueline Garonuk Wang, M.D.		29c. License number LES-000		29d. Date signed (Month, Day, Year) March 28, 2007
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JACQUELINE GARONUK WANG, M.D. 4940 EASTERN AVENUE BALTIMORE, MD 21224				
31. Date filed (Month, Day, Year) APR 03 2007		32. Registrar's Signature Jacqueline Garonuk Wang, M.D.		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1 - For State Registrar Amend # 25, 27,29a per PHYSICIAN Certificate of Death CNM

Reg. No. 2007 12428

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) BERNARD LEROY BUDESHEIM					2. Date of Death Month MARCH 30 Day , Year 2007	3. Time of Death 1:51 P M	
	4a. Facility Name (If not institution, give street and number) FREDERICK MEMORIAL HOSPITAL			4b. City, Town, or Location of Death FREDERICK		4c. County of Death FREDERICK		
Funeral Director	5. Social Security Number 175-10-5944	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 92 Yrs.	If Under 1 Year Months Days Hours Min.	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) JAN. 4, 1915	9. Birthplace (State or Foreign Country) Pennsylvania	
	10a. State Maryland			10b. County Washington		10c. City, Town or Location Boonsboro		
To Be Completed by Funeral Director	10e. Street and Number 18549 Breathedsville Rd.			10f. Zip Code 21713		10g. Citizen of What Country? United States		
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: White		14. Race - American Indian, Black, White, etc. Specify: White		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 9		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Railroad Conductor		16b. Kind of Business/Industry Transportation Railroad			
	17. Father's Name (First, Middle, Last) Harry Budesheim			18. Mother's Name (First, Middle, Maiden Surname) Maude Hartman				
	19a. Informant's Name/Relationship (Type, Print) Kimberly Kaiktsian / grndght.			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 18549 Breathedsville Rd./Boonsboro, MD 21713				
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) Mount Olivet Cem.		20b. Place of Disposition (Name of cemetery, crematory or other place)		Date 04/04/2007	20c. Location - City or Town, State Frederick, Maryland		
Physician /Medical Examiner	21. Signature of Funeral Service Licensee 			22. Name and Address of Facility Stauffer Funeral Home 1621 Opossumtown Pike/ Frederick, MD 21702				
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) RIGHT HIP FRACTURE							
	e. Due to (or as a consequence of): Appproved Robert Rohrer, MD							
	b. Due to (or as a consequence of): App. Plan Rohrer, MD							
	c. Due to (or as a consequence of): Plan							
	d. _____							
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome pf pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) 9/Unknown				23d. Date of delivery Month Day Year	
Medical Certification: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Renal Failure Hypertension Anemia							
	23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown							
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
	25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No							
	26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) Home							
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) 3/29/07	28b. Time of Injury 6 a M	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred Patient Fell		
	28e. Place of injury: At home, farm, street, factory, office building, etc. (Specify) Home							
	28f. Location (Street and Number or Rural Route Number, City or Town, State) 18549 Breathedsville Rd. Boonsboro, MD							
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
	29b. Signature and title of certifier 							
	29c. License number D246609							
	29d. Date signed (Month, Day, Year) 3/30/07							
State Registrar	31. Date filed (Month, Day, Year) APR 05 2007		32. Registrar's Signature 					

Baltimore, Maryland 21215-0036

Important: If item 27 is marked other than "natural"; or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death E.T., WCHD Reg. No. 2007 12429

Amended item

For
State
Registrar

#19a, per f. home, 4/10/2007,

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)	William Lee Bland				2. Date of Death Month April Day 4 Year 2007	3. Time of Death 12:30 a M
--	-------------------	--	--	--	---	-------------------------------

Willam Lee Bland

4a. Facility Name (If not institution, give street and number)

Atlantic General Hospital

4b. City, Town, or Location of Death

Berlin

4c. County of Death

Worcester

Funeral
Director

5. Social Security Number	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 82 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days Hours Min.	8. Date of Birth (Month, Day, Year) July 30, 1924	9. Birthplace (State or Foreign Country) VA
---------------------------	--	---	---------------------------	-------------------------------------	---	--

Usual Residence of Decedent

10a. State MD	10b. County Worcester	10c. City, Town or Location Ocean Pines	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
------------------	--------------------------	--	--

10e. Street and Number

20 Abbott Place

10f. Zip Code

21811

10g. Citizen of What Country?

USA

11. Marital Status

Never Married Married
 Widowed Divorced

12. Was Decedent Ever in U.S. Armed Forces?

Yes No
If Yes, Give Year or Dates:
1941 - 1945

13. Was Decedent of Hispanic Origin? (Specify Yes or No)
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

Yes No
Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12) College (1-4 or 5+)

4

16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

Sales

16b. Kind of Business/Industry

Door Company

17. Father's Name (First, Middle, Last)

Edward L. Bland

18. Mother's Name (First, Middle, Maiden Surname)

Margaret Lewis

19a. Informant's Name/Relationship (Type, Print)

Mary Anne Smith (wife)

Mary Anne Bland (wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

20 Abbott Place, Ocean Pines, Md. 21811

20a. Method of Disposition

Burial Cremation Removal from State
 Donation Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Cape Henlopen Crem.

Date

20c. Location - City or Town, State

4-5-2007

Frankford, DE

21. Signature of Funeral Service Licensee

► Kim MacLeod

22. Name and Address of Facility

The Burbage Funeral Home

108 William St., Berlin, Md. 21811

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Approximate Interval Between Onset and Death

a. metastatic prostate cancer

Due to (or as a consequence of):

Sequentially list conditions, Tally, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

If FEMALE:

23b. Was decedent pregnant in the past 12 months?
 Yes No
 Unknown

23c. If yes, outcome of pregnancy

Live birth Fetal death Ectopic pregnancy
 Pregnant at time of death Other (Specify)
 Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

Yes No Probably Unknown

25. Was case referred to medical examiner?
 Yes No

Hospital: Inpatient ER/Outpatient DOA Other: Nursing Home Residence Other (Specify)

27. Manner of Death

Natural Pending investigation
 Accident Could not be determined
 Suicide Determined
 Homicide

28a. Date of Injury
(Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

Yes No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

► J. van Egmond MD

29c. License number

DU056307

29d. Date signed (Month, Day, Year)

April 4, 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

J. van Egmond MD, Atlantic General Hospital, 9733 Healthway Drive, Berlin, MD 21811

31. Date filed (Month, Day, Year)

APR 05 2007

32. Registrar's Signature

James B. Spangler

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed

within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit

Division of Vital Records, P.O. Box 68760,

Bland, William L. D.O.B. 7/30/24 D.D. 4/4/07 T.O.D. 0030

BA 12+1

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend #28f, per ME, g867, 5/9/07 TT

State of Maryland / Department of Health and Mental Hygiene

**1- For State Amend PI, 25,27,28a-f, per ME, g867, 5/4/07 TE Certificate of Death
Registrar**

Reg. No. 2007 3130

Physician /Medical Examiner		1. Decedent's Name (First, Middle, Last)						2. Date of Death			3. Time of Death		
		Normalea Augusta Brown						Month	Day	Year	04 02 2007		0510 A M
Funeral Director		4a. Facility Name (If not institution, give street and number)						4b. City, Town, or Location of Death			4c. County of Death		
		Peninsula Regional Medical Center						Salisbury MD			Wicomico		
To Be Completed by Funeral Director		5. Social Security Number		6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)				
		214-30-7796		1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	73 Yrs.	Hours	Min.	9/10/1933	Maryland				
Usual Residence of Decedent		10a. State		10b. County		10c. City, Town or Location					10d. Inside City Limits		
Maryland		Maryland		Wicomico		Salisbury					1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
10e. Street and Number		10f. Zip Code						10g. Citizen of What Country?					
4599 Coulbourne Mill Road		21804						USA					
11. Marital Status		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: white					
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) - Office Manager			16b. Kind of Business/Industry Larry J. Causey & Sons, Inc.					
17. Father's Name (First, Middle, Last)		18. Mother's Name (First, Middle, Maiden Surname)											
Larry James Causey		Kathryn Victoria Willis											
19a. Informant's Name/Relationship (Type. Print)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)											
Hubert R. Brown/husband		4599 Coulbourne Mill Rd., Salisbury, MD 21804											
20a. Method of Disposition		20b. Place of Disposition (Name of cemetery, crematory or other place)			Date			20c. Location - City or Town, State					
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		Wicomico Memorial Park			4/6/07			Salisbury, MD					
21. Signature Funeral Service Licensee		22. Name and Address of Facility											
David H. Thompson CFSP		Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804											
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.		Approximate Interval Between Onset and Death											
Immediate Cause (Final disease or condition resulting in death)		+ DAY											
a. Due to (or as a consequence of): ANOXIC ENCEPHALOPATHY		+ DAY											
b. Due to (or as a consequence of): ASPIRATION		+ DAY											
c. Due to (or as a consequence of): DEMENTIA		2 YEARS											
d. Due to (or as a consequence of):													
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome pf pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 4 <input type="checkbox"/> Pregnant at time of death 9 <input type="checkbox"/> Unknown			3 <input type="checkbox"/> Ectopic pregnancy 5 <input type="checkbox"/> Other (specify) _____			23d. Date of delivery Month Day Year					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown											
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		26. Place of Death Check only one Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)											
27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input checked="" type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year) April 1, 2007			28b. Time of Injury unk. pm		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28d. Describe how injury occurred subject choked on bolus of food				
28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Home		28f. Location (Street and Number or Rural Route Number, City or Town, State) 4599 Coulbourne Rd. Mill Road Salisbury, MD											
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29c. License number D 4 6962											
29b. Signature and title of certifier Yousef Shirazi, M.D.		29d. Date signed (Month, Day, Year) APRIL 02, 2007											
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M. SHIRAZI, M.D. PENINSULA REGIONAL MEDICAL CENTER MD 21801.		31. Date filed (Month, Day, Year) APR 05 2007											
32. Registrar's Signature													

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene
Certificate of Death

Reg. No.

2007 12431

1- For State Registrar

Physician /Medical Examiner

Funeral Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division or Vital Records, P.O. Box 68760,

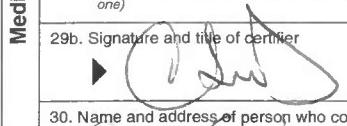
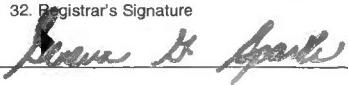
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Zoller

State Registrar

DHMH 17 Rev 1/2001

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year		3. Time of Death
<i>Edward Isaac Bonneville</i>		4	2	2007 0044A M
4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of Death		4c. County of Death
<i>Peninsula Regional Med. Center</i>		<i>Salisbury, MD</i>		<i>Nicomico</i>
5. Social Security Number		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) Yrs. <i>42</i>	If Under 1 Year Months Days Hours Min. <i>8-28-64</i>
8. Date of Birth (Month, Day, Year)		9. Birthplace (State or Foreign Country)		10. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
10a. State <i>Md.</i>		10b. County <i>Worcester</i>		10c. City, Town or Location <i>Snow Hill</i>
10e. Street and Number <i>413 Covington Street</i>		10f. Zip Code <i>21863</i>		10g. Citizen of What Country? <i>U. S. A.</i>
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: <i>1964</i>		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: <i>Black</i>
15. Decedent's Education (Specify only highest grade completed) <i>12th</i>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Construction worker</i>		16b. Kind of Business/Industry <i>Self-employed</i>
17. Father's Name (First, Middle, Last) <i>George Bonneville</i>		18. Mother's Name (First, Middle, Maiden Surname) <i>Goldie Mae Townsend</i>		
19a. Informant's Name/Relationship (Type, Print) <i>Kittora Bonneville</i>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>413 Covington Street Snow Hill, Md 21863</i>		
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <i>Jerusalemapt. C.</i>		20b. Place of Disposition (Name of cemetery, crematory or other place) <i>4-7-07 Temperanceville, VA</i>		Date <i>4-7-07</i>
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <i>Bennie Smith Funeral Home</i>		20c. Location - City or Town, State <i>917 Isabella Street, Salisbury, Md 21801</i>
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <i>ASCVD</i>		Approximate Interval Between Onset and Death <i>~</i>		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		a. Due to (or as a consequence of): <i>ASCVD</i>	b. Due to (or as a consequence of):	c. Due to (or as a consequence of):
		d. Due to (or as a consequence of):		
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome pf pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <i>Unknown</i>		23d. Date of delivery Month Day Year
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)	28b. Time of Injury M <i>1</i>	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 28d. Describe how injury occurred
		28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) <i>At home</i>	28f. Location (Street and Number or Rural Route Number, City or Town, State) <i>100 E Carroll St.</i>	
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier  <i>H0050497</i>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Chris Snyder DME</i>		29c. License number <i>H0050497</i>		29d. Date signed (Month, Day, Year) <i>4/2/07</i>
31. Date filed (Month, Day, Year) <i>APR 04 2007</i>		32. Registrar's Signature 		

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 12432

1- For
State
RegistrarPhysician
/Medical
ExaminerFuneral
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last)

REV. JOHN ERNEST BRADBURN, SR.

2. Date of Death
Month Day Year
April 02 2007 6:25 PM

3. Time of Death

4a. Facility Name (If not institution, give street and number)

Civista Medical Center

4b. City, Town, or Location of Death

La Plata

4c. County of Death

Charles

5. Social Security Number

577-46-8806

6. Sex

XXM 2□F

7. Age (In yrs. last birthday)

72

Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Days

8. Date of Birth
(Month, Day, Year)

Hours

Min.

FEB. 2, 1935

9. Birthplace (State or Foreign Country)

WASH., DC

10a. State

MARYLAND

10b. County

CHARLES

10c. City, Town or Location

INDIAN HEAD

10d. Inside City Limits

1□ Yes 2☒ No

10e. Street and Number

5695 PORT TOBACCO ROAD

10f. Zip Code

20640

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1□ Never Married XXMarried
3□ Widowed 4□ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1☒ Yes 2□ No
If Yes, Give Year or Dates: 1961

13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1□ Yes XXNo Specify:

14. Race - American Indian, Black, White, etc.

Specify: U.S.A.

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12) 12

College (1-4 or 5+) 4

16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

PASTOR

16b. Kind of Business/Industry

BAPTIST CHURCH

17. Father's Name (First, Middle, Last)

RALPH C. BRADBURN

18. Mother's Name (First, Middle, Maiden Surname)

ALICE JULIA COFFIN

19a. Informant's Name/Relationship (Type, Print)

MARJORIE BRADBURN-SPOUSE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5695 PORT TOBACCO RD., INDIAN HEAD, MD 20640

20a. Method of Disposition

1☒ Burial 2□ Cremation 3□ Removal from State
4□ Donation 5□ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

TRINITY MEMORIAL GDNS. 4-11-07 WALDORF, MARYLAND

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

M00479 22. Name and Address of Facility

RAYMOND FUNERAL SERVICE, P.A.

LA PLATA, MARYLAND 20646

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one condition on each line.

Immediate Cause (Final disease or condition resulting in death)

Approximate Interval Between Onset and Death

x years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

- a. Due to (or as a consequence of):
Coronary Artery Disease
- b. Due to (or as a consequence of):
Diabetes Mellitus
- c. Due to (or as a consequence of):
Renal Disease
- d.

x years

x years

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?
1□ Yes 2☒ No
9□ Unknown23c. If yes, outcome of pregnancy
1□ Live birth 2□ Fetal death 3□ Ectopic pregnancy
4□ Pregnant at time of death 5□ Other (Specify)
9□ Unknown23d. Date of delivery
Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1□ Yes 2☒ No 3□ Probably 4□ Unknown

25. Was case referred to medical examiner?

1□ Yes 2☒ No

26. Place of Death (Check only one)

Hospital: 1☒ Inpatient 2□ ER/Outpatient 3□ DOA

Other: 4□ Nursing Home 5□ Residence 6□ Other (Specify)

27. Manner of Death

1☒ Natural 5□ Pending investigation
2□ Accident 6□ Could not be determined
3□ Suicide
4□ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M 1□ Yes 2□ No

28c. Injury at Work?

1□ Yes 2□ No

28d. Describe how injury occurred

29a. Certifier
(Check only one)1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2□ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

D-20629

29d. Date signed (Month, Day, Year)

4/3/07

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

George H. Wathen MD, FACP 11345 Pembroke Sq. Waldorf, Md. 20603 Suite 103

31. Date filed (Month, Day, Year)

APR 18 2007

32. Registrar's Signature

Division or Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2007 12433

1- For State
Registrar

Reg. No.

**Physician/
Medical Examiner**

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Pamela Castaneda	March 28, 2007	1725 hrs

4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
University of Maryland Medical Center	Baltimore	Baltimore City

**Funeral
Director**

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth (MM/DD/YYYY)	9. Birthplace (State or Foreign Country)
603-48-6303	1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	15 Yrs.	Months	Days	06/27/1991	California

Baltimore, MD 21215-0036
 permit Pages 1 and 2 should be filed within 72 hours after death with the Maryland
 Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a show any
 injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
Maryland	Anne Arundel	Edgewater	

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
401A Bay View Drive	21037	United States

11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Specify Yes or No) 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No specify: El Salvadoran	14. Race - American Indian, Black, White, etc. Specify: White
--	---	--	--

15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 9	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Student	16b. Kind of Business/Industry Education
--	--	---

17. Father's Name (First, Middle, Last) Rodolfo Erivero Castaneda	18. Mother's Name (First, Middle, Maiden Surname) Maria Mercedes Vasquez
--	---

19a. Informant's Name/Relationship (Type, Print) Maria M. Vasquez/Mother	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 401A Bay View Drive, Edgewater, Maryland 21037
---	---

20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input checked="" type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other Specify:	20b. Place of Disposition (Name of cemetery, crematory or other place) Holy Cross Cemetery	Date 04/02/2007	20c. Location - City or Town, State Culver City, California
--	---	--------------------	--

21. Signature of Funeral Service Licensee 	22. Name and Address of Facility George P. Kalas Funeral Home, P.A. 2973 Solomons Island Road, Edgewater, Maryland 21037
--	--

**Physician
/Medical
Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.	Approximate Interval Between Onset and Death
---	--

Immediate Cause (Final disease or condition resulting in death)	a. Multiple Injuries Due to (or as a consequence of):
---	--

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):
--	--

c. Due to (or as a consequence of):	d. Due to (or as a consequence of):
--	--

<input type="checkbox"/> UNPENDED	<input type="checkbox"/> AMENDED
-----------------------------------	----------------------------------

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input checked="" type="checkbox"/> Unknown	23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown	23d. Date of delivery Month Day Year
---	---	---

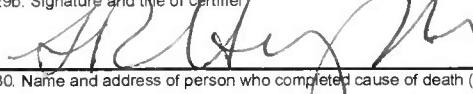
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown
--	--

23f. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other:
--	--

27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input checked="" type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide	28a. Date of Injury (Month, Day, Year) Mar 27, 2007	28b. Time of Injury 1555 hrs	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	28d. Describe how injury occurred Occupant auto fixed object collision
---	--	---------------------------------	---	---

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Local Street	28f. Location (Street and Number or Rural Route Number, City or Town, State) Muddy Creek Road & Central Avenue, Edgewater, MD
--	--

29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
--

29b. Signature and title of certifier 	29c. License number O.C.M.E.	29d. Date signed (Month, Day, Year) March 30, 2007
--	---------------------------------	---

30. Name and address of person who completed cause of death (Item 23a) Susan Hogan MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

31. Date filed (Month, Day, Year) APR 02 2007	32. Registrar's Signature 
--	--

Division of Vital Records, P.O. Box 68760,
 To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the "burial - transit

Medical Certification: To Be Completed by Physician/Medical Examiner**State
Registrar**

DHMH 17 Rev 1/2001

OCME 2006

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 12631

1- For State Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Ronald Edward Craig					2. Date of Death Month March Day 30 Year 2007	3. Time of Death 8:49 P M	
	4a. Facility Name (If not institution, give street and number) Anne Arundel Medical Center			4b. City, Town, or Location of Death Annapolis		4c. County of Death Anne Arundel		
Funeral Director	5. Social Security Number 579-42-6011	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 73 Yrs.	If Under 1 Year Months Days Hours Min.	8. Date of Birth (Month, Day, Year) Feb. 4, 1934	9. Birthplace (State or Foreign Country) Washington, DC		
To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State Maryland 10b. County Anne Arundel			10c. City, Town or Location Annapolis			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
	10e. Street and Number 904 Berwick Drive			10f. Zip Code 21403		10g. Citizen of What Country? U.S.A.		
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: 1953-55	13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: White	14. Race - American Indian, Black, White, etc. Specify: White				
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 2	Photographer	16b. Kind of Business/Industry NASA				
	17. Father's Name (First, Middle, Last) H. Craig	18. Mother's Name (First, Middle, Maiden Surname) (unknown)						
	19a. Informant's Name/Relationship (Type, Print) Joyce Craig/wife	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 904 Berwick Drive Annapolis, Maryland 21403						
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)	20b. Place of Disposition (Name of cemetery, crematory or other place) Baltimore Crematory	Date 4/2/2007	20c. Location - City or Town, State Baltimore, Maryland				
	21. Signature of Funeral Service Licensee ► <i>Ford E. Miller</i>	22. Name and Address of Facility John M. Taylor Funeral Home 147 Duke of Gloucester St., Annapolis, MD 21401						
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. <i>Adult Respiratory Distress Syndrome</i> Due to (or as a consequence of): <i>Pneumonia.</i>				Approximate Interval Between Onset and Death		
		b.	Due to (or as a consequence of):					
		c.	Due to (or as a consequence of):					
		d.						
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown	23c. If yes, outcome pf pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 9 <input type="checkbox"/> Unknown 5 <input type="checkbox"/> Other (specify) _____	23d. Date of delivery Month Day Year					
Medical Certification: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		
						24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury M	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred			
		28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
	29b. Signature and title of certifier ► <i>Stephen Olexo</i>	29c. License number D58510			29d. Date signed (Month, Day, Year) 03/30/07			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Stephen Olexo AMC	2001 Medical Parkway Annapolis, MD 21401						
	31. Date filed (Month, Day, Year) APR 02 2007	32. Registrar's Signature <i>Stephan Olexo</i>						

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2007 12435

Certificate of Death

Reg. No.

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last)							2. Date of Death Month Day Year	3. Time of Death		
	Berlee Chambers, Sr.							March 27 2007	10:50 P M		
Funeral Director	4a. Facility Name (If not institution, give street and number)			4b. City, Town, or Location of Death			4c. County of Death				
	St. Thomas More Nursing Home			Hyattsville			Prince George's				
5. Social Security Number		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) Yrs. 84	If Under 1 Year Months	If Under 24 Hrs. Days	Hours	Min.	8. Date of Birth (Month, Day, Year) Mar. 15, 1923	9. Birthplace (State or Foreign Country) North Carolina		
Usual Residence of Decedent		10a. State DC		10b. County		10c. City, Town or Location Washington			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
10e. Street and Number 732 Quincy St., NW		10f. Zip Code 20011			10g. Citizen of What Country? United States						
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. African American Specify: American				
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 9th		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Bricklayer		16b. Kind of Business/Industry Private							
17. Father's Name (First, Middle, Last) John Chambers				18. Mother's Name (First, Middle, Maiden Surname) Lacy Miller							
19a. Informant's Name/Relationship (Type, Print) Berlee Chambers, Jr./Son				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 732 Quincy St., NW Wash., DC 20011							
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Arlington National Cemetery		Date	20c. Location - City or Town, State Arlington, VA						
21. Signature of Funeral Service Licensee ► John T. Stewart III		22. Name and Address of Facility Stewart Funeral Home 4001 Benning Rd., NE Wash., DC 20019									
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		Approximate Interval Between Onset and Death									
b. { Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		a. <i>Atherosclerotic cardiovascular disease</i>									
		Due to (or as a consequence of):									
		<i>HIV +ve / AIDS</i>									
		c. Due to (or as a consequence of): d. Due to (or as a consequence of):									
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome pf pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year							
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown									
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred					
		28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.											
29b. Signature and title of certifier ► <i>T. Ahmad IC AHMED, MD</i>		29c. License number D0060100				29d. Date signed (Month, Day, Year) 03-30-07					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) T. Ahmad IC AHMED, MD		31. Date filed (Month, Day, Year) APR 04 2007									
32. Registrar's Signature <i>Michael A. Smith</i>											

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

permit: Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

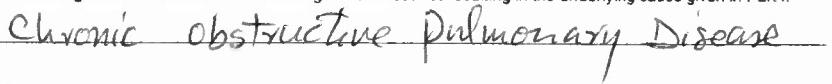
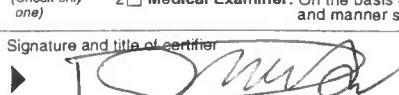
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007

12436

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last)							2. Date of Death	3. Time of Death	
	Charles C Carey							Month Day Year	Mar. 31, 2007	3:50 P M
Funeral Director	4a. Facility Name (If not institution, give street and number)			4b. City, Town, or Location of Death			4c. County of Death			
	9008 Magnolia Avenue			Lanham			Prince George's			
5. Social Security Number		6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	9. Birthplace (State or Foreign Country)			
579-12-0681		1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	82 Yrs.	Months	Days	Hours Min.	07-14-1924		New Jersey	
Usual Residence of Decedent										
10a. State	10b. County	10c. City, Town or Location							10d. Inside City Limits	
Maryland	Prince George's	Lanham							1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
10e. Street and Number				10f. Zip Code			10g. Citizen of What Country?			
9008 Magnolia Avenue				20706			U.S.A.			
11. Marital Status		12. Was Decedent Ever in U.S. Armed Forces?			13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)			14. Race - American Indian, Black, White, etc.		
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: 1943-1945			1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			Specify: White		
15. Decedent's Education (Specify only highest grade completed)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)			16b. Kind of Business/Industry			
Elementary/Secondary (0-12)		College (1-4 or 5+)		Dry Cleaning Salesman			International Harvester Dealers			
17. Father's Name (First, Middle, Last)				18. Mother's Name (First, Middle, Maiden Surname)						
Charles Alonzo Carey				Emily Louise Abdill						
19a. Informant's Name/Relationship (Type, Print)										
Mae Carey - Wife										
20a. Method of Disposition		20b. Place of Disposition (Name of cemetery, crematory or other place)			Date		20c. Location - City or Town, State			
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		Fort Lincoln Cemetery			4/4/2007		Brentwood, Maryland			
21. Signature of Funeral Service Licensee										
										
22. Name and Address of Facility										
Gasch's Funeral Home, P.A. Hyattsville, MD 20781										
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.										
Immediate Cause (Final disease or condition resulting in death)										
a.  Due to (or as a consequence of):										
b. _____ Due to (or as a consequence of):										
c. _____ Due to (or as a consequence of):										
d. _____										
Approximate Interval Between Onset and Death										
3 months										
23b. IF FEMALE: Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify)			23d. Date of delivery Month Day Year					
23e. Did tobacco use contribute to the cause of death? 										
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown										
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No										
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No										
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No										
26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)										
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		
				M						
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)										
28f. Location (Street and Number or Rural Route Number, City or Town, State)										
29a. Certifier 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
29b. Signature and title of certifier  M.D.										
29c. License number D 22549										
29d. Date signed (Month, Day, Year) April 02, 2007										
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) G. M. DIN, M.D. 6510 Kenilworth Ave, Suite # 2600 Riverdale MD 20737										
31. Date filed (Month, Day, Year) APR 04 2007										
32. Registrar's Signature 										

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit source.

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

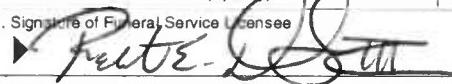
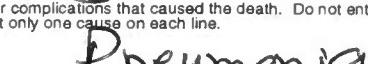
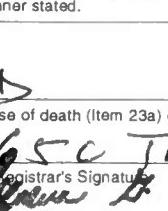
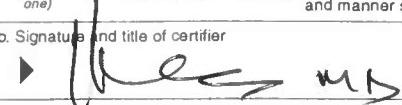
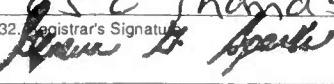
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2007 12437

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last)				2. Date of Death Month Day Year	3. Time of Death
	Manuel Charuhas				04 03 2007	9:30 AM
Funeral Director	4a. Facility Name (If not institution, give street and number) Golden Living Center				4b. City, Town, or Location of Death Frederick	4c. County of Death Frederick
	5. Social Security Number 579-26-3038	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 80 Yrs.	If Under 1 Year Months Days Hours Min.	8. Date of Birth (Month, Day, Year) July 19, 1926	9. Birthplace (State or Foreign Country) D.C.
To Be Completed by Funeral Director	10a. State Maryland				10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	10b. County Frederick				10c. City, Town or Location Frederick	
	10e. Street and Number 30 North Place				10f. Zip Code 21701	10g. Citizen of What Country? U.S.A.
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: WWII		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 2 Supervisor		16b. Kind of Business/Industry Office Machinery	
	17. Father's Name (First, Middle, Last) John Charuhas				18. Mother's Name (First, Middle, Maiden Surname) Kate Sigros	
	19a. Informant's Name/Relationship (Type, Print) Dorothy B. Charuhas / Wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6816 Falstone Drive, Frederick, MD 21702	
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Parklawn Mem. Park		Date 4/7/07	20c. Location - City or Town, State Rockville, Maryland
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility ROBERT E. DAILEY & SON FUNERAL HOMES, P.A. 1201 NORTH MARKET ST., FREDERICK, MD 21701	
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a.  Due to (or as a consequence of):				Approximate Interval Between Onset and Death	
	b. _____ Due to (or as a consequence of):					
	c. _____ Due to (or as a consequence of):					
	d. _____ Due to (or as a consequence of):					
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 				23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death Check on one Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Injury at Work? 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year) M		28d. Describe how injury occurred	
			28b. Time of Injury M		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	
	29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29c. License number 		29d. Date signed (Month, Day, Year) 4/3/07	
	29b. Signature and title of certifier 		29c. License number DOO60417		29d. Date signed (Month, Day, Year) 4/3/07	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hemen Shah 650 Thomas Johnson Dr, Frederick				31. Date filed (Month, Day, Year) APR 05 2007	
					32. Registrar's Signature 	

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

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To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit slip.

Medical Certification; To Be Completed by Physician/Medical Examiner

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

5/1/07

State
Registrar

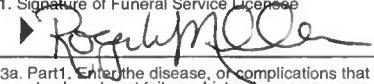
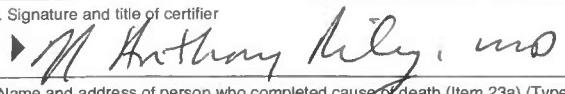
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 12438

1- For State Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last)						2. Date of Death Month Day Year	3. Time of Death				
	John Harold Charity, Jr.			April 3, 2007		7:43 A.M.						
Funeral Director	4a. Facility Name (If not institution, give street and number)			4b. City, Town, or Location of Death			4c. County of Death					
	Gilchrist Hospice			Towson			Baltimore					
To Be Completed by Funeral Director	5. Social Security Number	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 45 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) July 7, 1961	9. Birthplace (State or Foreign Country) Maryland					
	Usual Residence of Decedent			10c. City, Town or Location			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
10a. State Maryland			10b. County Frederick			10e. Street and Number 104 Evergreen Court			10f. Zip Code 21701	10g. Citizen of What Country? USA		
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: Black			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 3			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Account Executive			16b. Kind of Business/Industry Retail Professional						
17. Father's Name (First, Middle, Last) John Harold Charity, Sr.						18. Mother's Name (First, Middle, Maiden Surname) Alice Selden						
19a. Informant's Name/Relationship (Type, Print) John H. Charity, Sr./Father			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 104 Evergreen Court, Frederick, MD 21701			20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) Resthaven Mem. Gard			Date 4/6/2007	20c. Location - City or Town, State Frederick, MD 21702		
21. Signature of Funeral Service Licensee 			22. Name and Address of Facility Stauffer Funeral Home, PA 1621 Opossumtown Pike, Frederick, MD 21702									
23a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)						Approximate Interval Between Onset and Death Years						
a. Due to (or as a consequence of): Colon cancer												
b. Due to (or as a consequence of):												
c. Due to (or as a consequence of):												
d. Due to (or as a consequence of):												
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown			23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year						
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown						
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) Hospice									
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide			28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred					
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29b. Signature and title of certifier 			29c. License number 025205			29d. Date signed (Month, Day, Year) April 3, 2007						
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) W.A.R. Lay GME 6701 N. Charles St. Balt. MD 2120k												
31. Date filed (Month, Day, Year) APR 05 2007			32. Registrar's Signature 									

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Q

Medical Certification: To Be Completed by Physician/Medical Examiner

State Registrar

VOID

CERTIFICATE #

2007-12439

SEE

CERTIFICATE #

2006-36977

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2007 12440

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Frank M. Clark							2. Date of Death Month 4 Day 3 Year 2007	3. Time of Death 1:44 PM				
	4a. Facility Name (If not institution, give street and number) Atlantic General Hospital				4b. City, Town, or Location of Death Berlin			4c. County of Death Worcester					
Funeral Director	5. Social Security Number 199-28-1264		6. Sex M	7. Age (In yrs. last birthday) 71 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) 9 16 1935	9. Birthplace (State or Foreign Country) PA					
Usual Residence of Decedent													
To Be Completed by Funeral Director	10a. State PA	10b. County Chester	10c. City, Town or Location Chester						10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
10e. Street and Number 1327 Sherwood Drive				10f. Zip Code 19380				10g. Citizen of What Country? USA					
Physician /Medical Examiner	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: 1935		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: White			14. Race - American Indian, Black, White, etc. Specify: White				
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)					16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Postal Worker				16b. Kind of Business/Industry U.S. Postal Service				
17. Father's Name (First, Middle, Last) George B. Clark					18. Mother's Name (First, Middle, Maiden Surname) Ruth Hess Clark								
19a. Informant's Name/Relationship (Type, Print) Cary M. Clark					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1327 Sherwood Drive, West Chester, PA 19380								
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) Karen MacLeod					20b. Place of Disposition (Name of cemetery, crematory or other place) Cape Henlopen Crem.		Date 04/04/2007	20c. Location - City or Town, State Frankford, DE					
21. Signature of Funeral Service Licensee Karen MacLeod					22. Name and Address of Facility The Burbage Funeral Home 108 William St., Berlin, MD 21811								
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.													
Immediate Cause (Final disease or condition resulting in death) a. Hypoxic encephalopathy Due to (or as a consequence of):													
b. Due to (or as a consequence of):													
c. Due to (or as a consequence of):													
d. _____													
Approximate Interval Between Onset and Death													
23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown					23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Unknown					23d. Date of delivery Month Day Year			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
										24a. Was an autopsy performed? <input type="checkbox"/> Yes <input type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
										25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)										26. Place of Death (Check only one)			
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide										28a. Date of Injury (Month, Day Year) May	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred
										28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) At home		28f. Location (Street and Number or Rural Route Number, City or Town, State) Baltimore, Maryland 21215-0036	
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										29d. Date signed (Month, Day, Year) 4/3/07			
29b. Signature and title of certifier Andrea K. Baker, MD										29c. License number DS3612			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Andrea K. Baker, MD 9733 Highway Dr. Berlin, MD 21811										31. Date filed (Month, Day, Year) APR 05 2007	32. Registrar's Signature Karen MacLeod		

Baltimore, Maryland 21215-0036

FRANK M CLARK DIB 9/16/1933
19928 1264 DED 4/3/2007 1344Division of Vital Records, P.O. Box 68760,
Medical Certification: To Be Completed by Physician/Medical Examiner
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transitState
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 1244

1- For
State
Registrar

Physician
/Medical
Examiner

Funeral
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036
Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or items 23a or 28a-1 show
any injury or other traumatic event, the Medical Examiner must be notified at
once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial/transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year April 10 2007				3. Time of Death 0040 A M			
Susanna L. Cole									
4a. Facility Name (If not institution, give street and number) Laurelwood Care Center		4b. City, Town, or Location of Death Elkton				4c. County of Death Cecil			
5. Social Security Number 217-09-8934		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 89 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days Hours Min.	8. Date of Birth (Month, Day, Year) SEPT 6, 1917	9. Birthplace (State or Foreign Country) Wisconsin		
Usual Residence of Decedent Delaware		10b. County New Castle		10c. City, Town or Location Newark			10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		
10e. Street and Number 208 Murray Avenue		10f. Zip Code 19711				10g. Citizen of What Country? United States			
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker		16b. Kind of Business/Industry In Her Own Home					
17. Father's Name (First, Middle, Last) Frank William Guns				18. Mother's Name (First, Middle, Maiden Surname) Anna Schneiders					
19a. Informant's Name/Relationship (Type, Print) Charles L. Cole, Jr./Son				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 161 Providence Road, Elkton, Maryland 21921					
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Immaculate Conception Cemetery		Date April 13, 2007	20c. Location - City or Town, State Cherry Hill, Maryland				
21. Signature of Funeral Service Licensee ► Donald S. Hicks		22. Name and Address of Facility Hicks Home for Funerals, P.A. 103 W. Stockton Street, Elkton, Maryland 21921							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death	
<p>a. Due to (or as a consequence of): Failure to Thrive</p> <p>b. Due to (or as a consequence of): Severe Dementia</p> <p>c. Due to (or as a consequence of):</p> <p>d. Due to (or as a consequence of):</p>									
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown				23d. Date of delivery Month Day Year			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						23f. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown	
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred			
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician 2 <input type="checkbox"/> Medical Examiner		29b. Signature and title of certifier ► Alan Stone, MD						29c. License number DSY073	
								29d. Date signed (Month, Day, Year) 10 APR 07	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Alan Stone, MD 817 CHURCHMAN ST NEWCASTLE DE 19720									
31. Date filed (Month, Day, Year) APR 18 2007		32. Registrar's Signature Alan S. Speller							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

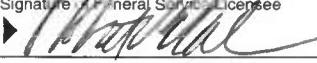
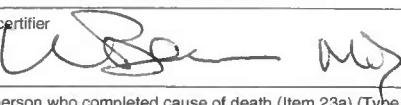
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2007 12142

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Earl Joseph Donnelly				2. Date of Death Month Day Year March 23, 2007		3. Time of Death 7:00 A M	
	4a. Facility Name (If not institution, give street and number) 1067 Carrs Wharf Road		4b. City, Town, or Location of Death Edgewater			4c. County of Death Anne Arundel		
Funeral Director	5. Social Security Number 577-22-5074	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 84 Yrs.	If Under 1 Year Months Days Hours Min.	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) 08/24/1922	9. Birthplace (State or Foreign Country) Pennsylvania	
	Usual Residence of Decedent 10a. State Maryland		10b. County Anne Arundel			10c. City, Town or Location Edgewater		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
To Be Completed by Funeral Director	10e. Street and Number 1067 Carrs Wharf Rd.			10f. Zip Code 21037		10g. Citizen of What Country? United States		
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: W.W.II		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Salesman		16b. Kind of Business/Industry Sporting Goods			
	17. Father's Name (First, Middle, Last) Earl J. Donnelly, Sr.				18. Mother's Name (First, Middle, Maiden Surname) Lillian Turgeon			
	19a. Informant's Name/Relationship (Type, Print) Margaret G. Donnelly/Wife		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1067 Carrs Wharf Road, Edgewater, Maryland 21037					
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Kalas Crematory		Date 03/24/2007	20c. Location - City or Town, State Edgewater, Maryland		
	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037					
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)				Approximate Interval Between Onset and Death 2 weeks			
	a. Due to (or as a consequence of): Metastatic Lung Cancer							
	b. Due to (or as a consequence of): Tobacco							
	c. Due to (or as a consequence of):							
	d. Due to (or as a consequence of):							
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome pf pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year		
Medical Certification: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Hypertension, Osteopenia, Emphysema				23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death Check only one Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
			28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)					28f. Location (Street and Number or Rural Route Number, City or Town, State)
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
	29b. Signature and title of certifier 		29c. License number D36488		29d. Date signed (Month, Day, Year) 3/23/07			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) William Behrens MD 2448 Holly Ave St 100 Anna Md 21401							
ST1	31. Date filed (Month, Day, Year) MAR 26 2007		32. Registrar's Signature 					

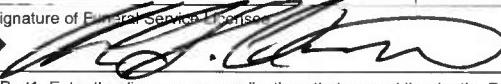
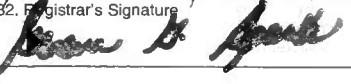
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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 12443

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Jan Annette Downs							2. Date of Death Month March Day 22 , Year 2007	3. Time of Death 9:30 AM M
	4a. Facility Name (If not institution, give street and number) Baltimore Washington Medical Center Glen Burnie Anne Arundel				4b. City, Town, or Location of Death Glen Burnie Anne Arundel			4c. County of Death Anne Arundel	
Funeral Director	5. Social Security Number 219-54-4881		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 56 Yrs.	If Under 1 Year Months 0 Days 0	If Under 24 Hrs. Hours 0 Min. 0	8. Date of Birth (Month, Day, Year) 11/05/1950	9. Birthplace (State or Foreign Country) Virginia	
	Usual Residence of Decedent Maryland		10a. State Maryland		10b. County Anne Arundel			10c. City, Town or Location Edgewater	
To Be Completed by Funeral Director	10e. Street and Number 1724 Forestville Road				10f. Zip Code 21037			10g. Citizen of What Country? United States	
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: 1980		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: White			14. Race - American Indian, Black, White, etc. Specify: White	
Physician /Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Caregiver		16b. Kind of Business/Industry Home Health				
	17. Father's Name (First, Middle, Last) John A. Davis		18. Mother's Name (First, Middle, Maiden Surname) Evelyn Thomas						
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Robert N. Curran/Son				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1724 Forestville Road, Edgewater, Maryland 21037				
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) Nat'l. Mem. Park		20b. Place of Disposition (Name of cemetery, crematory or other place) Nat'l. Mem. Park		Date 03/27/2007	20c. Location - City or Town, State Falls Church, Virginia			
Medical Certification: To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd., Edgewater, MD 21037				
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Pneumonia				Approximate Interval Between Onset and Death				
Physician /Medical Examiner	23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown				23c. If yes, outcome pf pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Other (specify) Other (specify)				
	23d. Date of delivery Month 03 Day 22 Year 2007								
Medical Certification: To Be Completed by Physician/Medical Examiner	23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown				23f. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				
Physician /Medical Examiner	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide			
			28a. Date of Injury (Month, Day, Year) 03/22/2007			28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred	
Medical Certification: To Be Completed by Physician/Medical Examiner	28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) At home, Glen Burnie, MD				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
Physician /Medical Examiner	29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier  Kofi Boraiye, MD				
					29c. License number 248006				
Physician /Medical Examiner	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kofi Boraiye, 301 Hospital Dr., Glen Burnie, MD				29d. Date signed (Month, Day, Year) 03/22/2007				
	31. Date filed (Month, Day, Year) MAR 26 2007				32. Registrar's Signature 				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 12444

1- For
State
Registrar

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
William DeHaven	3 30 2007	5:29 A.M.

4a. Facility Name (If not institution, give street and number)

Washington Adventist Hospital

4b. City, Town, or Location of Death

Takoma Park

4c. County of Death

Montgomery

To Be Completed by Funeral Director

Permit: Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To Be Completed by Funeral Director

5. Social Security Number	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 54 Yrs.	8. Date of Birth (Month, Day, Year) 9/23/1952	9. Birthplace (State or Foreign Country) Roanoke, VA
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Usual Residence of Decedent

10a. State MD	10b. County Prince George's	10c. City, Town or Location Aldelphi	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
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10e. Street and Number
1836 Metzerott Road # 907

10f. Zip Code
20783

10g. Citizen of What Country?
United States

11. Marital Status

Never Married Married
 Widowed Divorced

12. Was Decedent Ever in U.S. Armed Forces?

Yes No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

Yes No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)
12

College (1-4 or 5+)

Metro Bus Operator

16b. Kind of Business/Industry
Transportation

17. Father's Name (First, Middle, Last)

Clarence William DeHaven

18. Mother's Name (First, Middle, Maiden Surname)

Elisabeth Diggs

19a. Informant's Name/Relationship (Type, Print)

Michael N. DeHaven (brother) 115 Greyfield Drive Tyrone, GA 30290

20a. Method of Disposition

Burial Cremation Removal from State
 Donation Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Fort Lincoln Crematory 4/6/2007

Date

20c. Location - City or Town, State

Brentwood, MD

21. Signature of Funeral Service Licensee



22. Name and Address of Facility

Fort Lincoln Funeral Home
3401 Bladensburg Road Brentwood, MD 20722

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Approximate Interval Between Onset and Death

Sepsis

Due to (or as a consequence of):

Multorgan Failure

Due to (or as a consequence of):

ARDS pneumonia

Due to (or as a consequence of):

Acute Renal Failure

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?
 Yes No
 Unknown

23c. If yes, outcome of pregnancy

Live birth Fetal death Ectopic pregnancy
 Pregnant at time of death Other (specify) _____
 Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

Yes No Probably Unknown

25. Was case referred to medical examiner?

Yes No

26. Place of Death (Check only one)

Hospital: Inpatient ER/Outpatient DCA

Other: Nursing Home Residence Other (Specify)

27. Manner of Death

Natural Pending investigation
 Accident Could not be determined
 Suicide Determined
 Homicide

28a. Date of Injury
(Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

Yes No

28d. Describe how injury occurred

29a. Certifier
(Check only one)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier



29c. License number

D 0064024

29d. Date signed (Month, Day, Year)

4/02/07

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Janna Zachtchindina, MD ; WATH 7600 Carroll Ave Takoma Park, MD

31. Date filed (Month, Day, Year)

APR 03 2007

32. Registrar's Signature


Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene
Certificate of Death2007 12445
Reg. No.1- For
State
RegistrarPhysician
/Medical
ExaminerFuneral
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

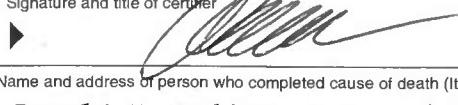
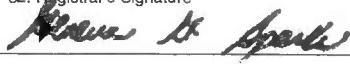
Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division or Vital Records, P.O. Box 68760,

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year				3. Time of Death	
Mildred Louise Dayhoff		April 2 2007				1:15 am	
4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of Death				4c. County of Death	
Golden Living Center		Frederick				Frederick	
5. Social Security Number		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 84 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days Hours Min.	8. Date of Birth (Month, Day, Year) May 27, 1922	9. Birthplace (State or Foreign Country) West Virginia
Usual Residence of Decedent						10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10a. State Maryland	10b. County Frederick	10c. City, Town or Location Middletown				10g. Citizen of What Country? United States	
10e. Street and Number 4488 Willow Tree Drive		10f. Zip Code 21769				10g. Citizen of What Country? United States	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: Elementary/Secondary (0-12) 8		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: 15. Decedent's Education (Specify only highest grade completed) College (1-4 or 5+) Homemaker			14. Race - American Indian, Black, White, etc. Specify: White
17. Father's Name (First, Middle, Last) Sydnor Claude Gordon		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)				16b. Kind of Business/Industry Own Home	
19a. Informant's Name/Relationship (Type. Print) Betty L. Lockard / Sister		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4488 Willow Tree Drive Middletown, Maryland 21769				18. Mother's Name (First, Middle, Maiden Surname) Avery Eugenia Bush	
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Locust Grove Cemetery		Date April 6, 2007	20c. Location - City or Town, State Mt. Airy, Maryland		
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Stauffer Funeral Homes, P.A. 8 E. Ridgeville Blvd. Mt. Airy, Maryland 21771					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of): <i>Pneumonia</i> Approximate Interval Between Onset and Death 2-3 days							
b. Due to (or as a consequence of):							
c. Due to (or as a consequence of):							
d. Due to (or as a consequence of):							
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome pf pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____ <input type="checkbox"/> Unknown				23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Alzheimer's dementia</i>							
23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown							
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred		
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29c. License number <i>MD. 026499</i>				29d. Date signed (Month, Day, Year) <i>4-4-07</i>	
29b. Signature and title of certifier 							
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ronald E. Miller, M.D. 4 Culwell Drive Mt. Airy, Maryland 21771							
31. Date filed (Month Day Year) <i>APR 05 2007</i>		32. Registrar's Signature 					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2007 12446

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Nan Duer Earnest					2. Date of Death Month March Day 30 Year 2007	3. Time of Death 11:10 A M		
	4a. Facility Name (If not institution, give street and number) Anne Arundel Medical Center			4b. City, Town, or Location of Death Annapolis		4c. County of Death Anne Arundel			
Funeral Director	5. Social Security Number 212-40-1130		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 87 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Hours	8. Date of Birth (Month, Day, Year) March 14, 1920	9. Birthplace (State or Foreign Country) Virginia	
	10a. State Maryland		10b. County Anne Arundel	10c. City, Town or Location Annapolis				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
To Be Completed by Funeral Director	10e. Street and Number 405 Melvin Avenue			10f. Zip Code 21401			10g. Citizen of What Country? United States		
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: Year		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: White		14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 4 Homemaker			16b. Kind of Business/Industry Own Home		
	17. Father's Name (First, Middle, Last) Charles Boston Duer					18. Mother's Name (First, Middle, Maiden Surname) Ethel Cooley			
	19a. Informant's Name/Relationship (Type, Print) Charles Earnest, Jr./Son			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 403 Melvin Ave., Annapolis, Maryland 21401					
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) Hillcrest Mem. Gardens			20b. Place of Disposition (Name of cemetery, crematory or other place)		Date 4/3/07	20c. Location - City or Town, State Annapolis, Maryland		
	21. Signature of Funeral Service Licensee Michelle J. Kutta			22. Name and Address of Facility 147 Duke of Gloucester St., Annapolis, MD 21401					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Ischemic Brain Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Septic Shock								
	Approximate Interval Between Onset and Death 24 hours 24 hours								
	23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown			23c. If yes, outcome pf pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year		
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								
	23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown								
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA <input type="checkbox"/> Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		
	28a. Date of Injury (Month, Day Year)			28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred	
	28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)					
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
	29b. Signature and title of certifier Steven Bresnick			29c. License number DM35484			29d. Date signed (Month, Day, Year) 3/30/2007		
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Steve Bresnick Anne Arundel Medical Center								
Division or Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036	31. Date filed (Month, Day, Year) APR 02 2007			32. Registrar's Signature Anne Bresnick					

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2007 12447

1. For State
Registrar**Physician/
Medical Examiner**

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death 1100 hrs
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Jamie Patrick Elliott	March 28, 2007	
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4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
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Snow Hill Road / Rt. 13 Bypass

Salisbury

Wicomico

**Funeral
Director**

5. Social Security Number	6. Sex	7. Age (In yrs, last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth (MM/DD/YYYY)	9. Birthplace (State or Foreign Country)
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219-02-8485	1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	23 Yrs.	Months	Days	Hours	Min.	04/09/1983	Maryland
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Usual Residence of Decedent							10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
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10a. State Maryland	10b. County Wicomico	10c. City, Town or Location Salisbury					
------------------------	-------------------------	--	--	--	--	--	--

10e. Street and Number 4868 North Hampton Drive	10f. Zip Code 21804	10g. Citizen of What Country? USA
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11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No specify: Specify: white	14. Race - American Indian, Black, White, etc.
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15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) -	16b. Kind of Business/Industry Waiter/bartender	Food Service
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17. Father's Name (First, Middle, Last) Michael T. Elliott	18. Mother's Name (First, Middle, Maiden Surname) Donna Leigh Hastings
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19a. Informant's Name/Relationship (Type, Print) Michael Elliott/father	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4868 N. Hampton Dr., Salisbury, MD 21804
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20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other Specify:	20b. Place of Disposition (Name of cemetery, crematory or other place) Pittsville Cemetery	Date 4/3/07	20c. Location - City or Town, State Pittsville, MD
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21. Signature of Funeral Service Licensee Kelli R. Derry CFSP	22. Name and Address of Facility Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804
--	--

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)	a. Multiple Injuries Due to (or as a consequence of):	Approximate Interval Between Onset and Death
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Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. _____ Due to (or as a consequence of):	
--	--	--

c. _____ Due to (or as a consequence of):	d. _____ Due to (or as a consequence of):	
--	--	--

<input type="checkbox"/> UNPENDED	<input type="checkbox"/> AMENDED	
-----------------------------------	----------------------------------	--

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown	23d. Date of delivery Month Day Year
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1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown	23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown
---	--

24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
---	---

25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	26 Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DDA Other 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other Scene
---	---

27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input checked="" type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide	28a. Date of Injury Month Day Year Mar 28, 2007	28b. Time of Injury 1030 hrs	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	28d. Describe how injury occurred Driver of auto which struck fixed objects
--	---	---------------------------------	---	--

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Street	28f. Location (Street and Number or Rural Route Number, City or Town, State) Snow Hill Road / Rt. 13 bypass, Salisbury, MD
--	---

29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
--

29b. Signature and title of certifier Patricia Aronica-Pollak MD	29c. License number O.C.M.E.	29d. Date signed (Month, Day, Year) March 29, 2007
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30. Name and address of person who completed cause of death (Item 23a) Patricia Aronica-Pollak MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

31. Date filed (Month, Day, Year) APR 03 2007	32. Registrar's Signature Bruce A. Smith
--	---

ORIGINAL

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transit

within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician, page 2 should be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 12448

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) JOE D. EVANS					2. Date of Death Monthly Day Year April 10 2007	3. Time of Death 9:25 a.m.	
	4a. Facility Name (If not institution, give street and number) Gilchrist Center for Hospice Care			4b. City, Town, or Location of Death Baltimore		4c. County of Death Baltimore		
Funeral Director	5. Social Security Number 218-34-1940	6. Sex 1 M 2 F	7. Age (In yrs. last birthday) 70 Yrs.	If Under 1 Year Months Days Hours Min.	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) 3/19/1937	9. Birthplace (State or Foreign Country) Pennsylvania	
To Be Completed by Funeral Director	10a. State MD					10b. County Harford	10c. City, Town or Location Street	10d. Inside City Limits 1 Yes 2 No
	10e. Street and Number 3530 Prospect Road			10f. Zip Code 21154		10g. Citizen of What Country? United States		
	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No) 1 Yes 2 No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 5+			16b. Kind of Business/Industry Principal Public High School	
	17. Father's Name (First, Middle, Last) John Evans			18. Mother's Name (First, Middle, Maiden Surname) Gladys Hinton				
	19a. Informant's Name/Relationship (Type, Print) Betsy A. Evans/Wife			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3530 Prospect Road, Street, MD 21154				
Physician /Medical Examiner	20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Emory Cemetery	Date 4/14/2007	20c. Location - City or Town, State Street, MD		
	21. Signature of Funeral Service Licensee Jeffrey P. Landidge			22. Name and Address of Facility Harkins Funeral Home, Inc., Delta, PA 17314				
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Lung Cancer							
	Approximate Interval Between Onset and Death months							
	Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of): Lung Cancer							
	b. Due to (or as a consequence of):							
	c. Due to (or as a consequence of):							
	d. _____							
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown			23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown			23d. Date of delivery Month Day Year	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. chronic leukemia							
	23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown							
	24a. Was an autopsy performed? 1 Yes 2 No							
	24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No							
	25. Was case referred to medical examiner? 1 Yes 2 No		26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospice					
	27. Manner of Death 1 Natural 5 Pending investigation 2 Accident 6 Could not be determined 3 Suicide 4 Homicide		28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work 1 Yes 2 No	28d. Describe how injury occurred		
			28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) At home		28f. Location (Street and Number or Rural Route Number, City or Town, State) W.A. Riley GBMC 601 N Charles St. Baltimore MD 21205			
	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29c. License number 025205		29d. Date signed (Month, Day, Year) April 10, 2007			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) W.A. Riley GBMC 601 N Charles St. Baltimore MD 21205							
	31. Date filed (Month, Day, Year) APR 18 2007		32. Registrar's Signature Susan B. Spangler					

Baltimore, Maryland 21215-0036
 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
 Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Evans, Joe April 10, 2007 9:25 am

Division or Vital Records, P.O. Box 68760, *Joe*
 To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

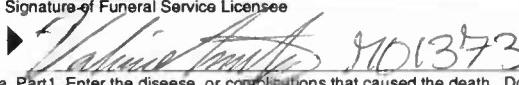
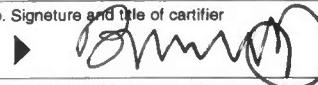
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene-

Certificate of Death

Reg. No.

2007 12449

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Virginia Illing Fisher					2. Date of Death Month Day Year Mar. 31, 2007	3. Time of Death 9:15 A	
	4e Facility Name (If not institution, give street and number) Sacred Heart Nursing Home			4b. City, Town, or Location of Death Hyattsville	4c. County of Death Prince George's			
Funeral Director	5. Social Security Number 084-20-5607	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 84 Yrs.	If Under 1 Year Months Days Hours Min. 0 0 0 0	8. Date of Birth (Month, Day, Year) Jan. 22, 1923	9. Birthplace (State or Foreign Country) New York		
To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State Maryland 10b. County Prince George's 10c. City, Town or Location Hyattsville						10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
	10e. Street and Number 5805 Queens Chapel Road			10f. Zip Code 20782	10g. Citizen of What Country? USA			
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: White	14. Race - American Indian, Black, White, etc.				
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 4	16b. Kind of Business/Industry Homemaker	Own Home				
	17. Father's Name (First, Middle, Last) Henry Illing	18. Mother's Name (First, Middle, Maiden Surname) Mabel Carley						
	19a. Informant's Name/Relationship (Type, Print) Janet Wasek - Daughter	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6009 39th Avenue, Hyattsville, MD 20782						
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)	20b. Place of Disposition (Name of cemetery, crematory or other place) Metropolitan Crematory	Date 4/3/07	20c. Location - City or Town, State Alexandria, Virginia				
	21. Signature of Funeral Service Licensee 	22. Name and Address of Facility Gasch's Funeral Home, P.A.	4739 Baltimore Ave. Hyattsville, MD 20781					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. e. Immediate Cause (Final disease or condition resulting in death) Alzheimers disease, end stage	Approximate Interval Between Onset and Death						
	e. Due to (or as a consequence of): b. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):							
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Hypertension Hyperlipidemia	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown						
		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No						
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred			
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)					
	29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
	29b. Signature and title of certifier 	29c. License number D51520 29d. Date signed (Month, Day, Year) 4/3/2007						
	30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Bahram Pishdad, MD 1328 Southern Ave SE, Ste 310, Washington, DC							
State Registrar	31. Date filed (Month, Day, Year) APR 04 2007	32. Registrar's Signature 						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit slip.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 12450

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>ANTHONY E. FARRIS</i>						2. Date of Death Month <input checked="" type="checkbox"/> April Day <input checked="" type="checkbox"/> 15 Year <input type="checkbox"/> 2007	3. Time of Death <input type="checkbox"/> 1:54 A M																																					
	4a. Facility Name (If not institution, give street and number) <i>BALTIMORE WASHINGTON Medical Center</i>			4b. City, Town, or Location of Death <i>Glen Burnie</i>			4c. County of Death <i>Anne Arundel</i>																																						
Funeral Director	5. Social Security Number 066-54-1507	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 48 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Hours	8. Date of Birth (Month, Day, Year) December 12, 1958	9. Birthplace (State or Foreign Country) Queens, New York																																						
To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State Maryland 10b. County Anne Arundel 10c. City, Town or Location Glen Burnie						10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No																																						
	10e. Street and Number 8113 Crispin Court			10f. Zip Code 21061			10g. Citizen of What Country? United States																																						
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: Black																																					
	15. Decedent's Education (Specify only highest grade completed) 12th grade			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Carpet Maker			16b. Kind of Business/Industry Edward Fields Carpet Company, Inc.																																						
	17. Father's Name (First, Middle, Last) (unknown)						18. Mother's Name (First, Middle, Maiden Surname) Jane Farris																																						
	19a. Informant's Name/Relationship (Type, Print) Mabel Marcus Farris (Wife)			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8113 Crispin Court; Glen Burnie, Maryland 21061																																									
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Plain View Cemetery			Date April 10, 2007	20c. Location - City or Town, State Hicksville, New York																																					
Physician /Medical Examiner	21. Signature of Funeral Service Licensee <i>Ronald B. Farris</i>			22. Name and Address of Facility R. N. Horton Company Morticians, Inc. 600 Kennedy Street, N.W.; Washington, D.C. 20011																																									
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, # any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last																																												
	<table border="1"> <tr> <td>a.</td> <td colspan="8">Due to (or as a consequence of): <i>SEPTIC SHOCK</i></td> </tr> <tr> <td>b.</td> <td colspan="8">Due to (or as a consequence of): <i>MONITORING ACROSS</i></td> </tr> <tr> <td>c.</td> <td colspan="8">Due to (or as a consequence of): <i>HIV / AIDS</i></td> </tr> <tr> <td>d.</td> <td colspan="8"></td> </tr> </table>									a.	Due to (or as a consequence of): <i>SEPTIC SHOCK</i>								b.	Due to (or as a consequence of): <i>MONITORING ACROSS</i>								c.	Due to (or as a consequence of): <i>HIV / AIDS</i>								d.								
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b.	Due to (or as a consequence of): <i>MONITORING ACROSS</i>																																												
c.	Due to (or as a consequence of): <i>HIV / AIDS</i>																																												
d.																																													
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown			23c. If yes, outcome pf pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown <input type="checkbox"/> Other (specify) _____			23d. Date of delivery Month Day Year																																						
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.																																												
	23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown																																												
	<table border="1"> <tr> <td>24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</td> <td>24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</td> </tr> </table>									24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No																																		
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	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)																																									
	27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide			28a. Date of Injury (Month, Day Year)			28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred																																				
				28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)																																						
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.																																												
	29b. Signature and title of certifier <i>Berlin</i>			29c. License number 10005703			29d. Date signed (Month, Day, Year) April 15, 2007																																						
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Baltimore Washington Medical Center Glen Burnie MD</i>																																												
	31. Date filed (Month, Day, Year) APR 04 2007			32. Registrar's Signature <i>Barbara B. Farris</i>																																									

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Farris Anthony E.
Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007

12451

1- For State Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Kaethe H. Flohr						2. Date of Death Month 04 Day 10 Year 2007	3. Time of Death 2:45 P.M.		
	4a. Facility Name (If not institution, give street and number) FRANKLIN SQUARE Hospital			4b. City, Town, or Location of Death ROSEDALE			4c. County of Death BALTIMORE			
Funeral Director	5. Social Security Number 252-56-1212	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 90 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) May 23, 1916	9. Birthplace (State or Foreign Country) Germany			
	Usual Residence of Decedent 10a. State MD 10b. County Baltimore 10c. City, Town or Location Essex						10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
To Be Completed by Funeral Director	10e. Street and Number 1000 Franklin Ave.			10f. Zip Code 21221			10g. Citizen of What Country? U.S.A.			
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 2			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Dealer			16b. Kind of Business/Industry Stamp and Coin Collector			
	17. Father's Name (First, Middle, Last) Otto Heinrich Flohr			18. Mother's Name (First, Middle, Maiden Surname) Frieda K. Dannhausen						
	19a. Informant's Name/Relationship (Type, Print) Irene Fisher, Daughter			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 352 Sweeney Court, New Freedom, PA 17349						
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input checked="" type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) New Freedom Cemetery		Date April 13, 2007	20c. Location - City or Town, State New Freedom, PA			
	21. Signature of Funeral Service License Hausey. Hartenstein			22. Name and Address of Facility J.J. Hartenstein Mortuary, Inc. 24 Second St., New Freedom, PA 17349						
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							Approximate Interval Between Onset and Death		
	<p>a. SEVERE COPD Due to (or as a consequence of):</p> <p>b. _____ Due to (or as a consequence of):</p> <p>c. _____ Due to (or as a consequence of):</p> <p>d. _____</p>									
Medical Certification: To Be Completed by Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown			23c. If yes, outcome pf pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____ <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year			
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. NOSOCOMIAL PNEUMONIA ISCHEMIC CARDIOMYOPATHY							23e. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
								24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide							28a. Date of Injury (Month, Day Year) M 28b. Time of Injury M 28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No 28d. Describe how injury occurred		
	28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)							28f. Location (Street and Number or Rural Route Number, City or Town, State)		
	29a. Certifier <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							29d. Date signed (Month, Day, Year)		
	29b. Signature and title of certifier Dr. IMRAN SIDDIQI							29c. License number D0063974 29d. Date signed (Month, Day, Year) 4/10/07		
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. IMRAN SIDDIQI 9000 FRANKLIN Square Dr. Baltimore, md. 21237							31. Date filed (Month, Day, Year) APR 18 2007 32. Registrar's Signature Barbara J. Gable		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2007 12452

1- For
State
Registrar

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Lorenza Diez Goudy

2. Date of Death

Month

Day

Year

MARCH 20, 2007

3. Time of Death

10:45PM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Saint Joseph Medical Center

4b. City, Town, or Location of Death

Towson

4c. County of Death

Baltimore

5. Social Security Number

214-62-3370

6. Sex

1 M 2 F

7. Age (In yrs. last birthday)

76

Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Days

Hours

Min.

8. Date of Birth

(Month, Day, Year)

1/11/1931

9. Birthplace (State or Foreign Country)

Spain

Usual Residence of Decedent

10a. State

MD Anne Arundel

10c. City, Town or Location

Crofton

10d. Inside City Limits

1 Yes 2 No

10e. Street and Number

1742 Swinburne Ave.

10f. Zip Code

21114

10g. Citizen of What Country?

Spain

11. Marital Status

1 Never Married 2 Married
3 Widowed 4 Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.
3 Yes 2 No Specify: Spanish

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)
8

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

Housekeeper

16b. Kind of Business/Industry

Housekeeping

17. Father's Name (First, Middle, Last)

Alejandro Diez Rodriguez

18. Mother's Name (First, Middle, Maiden Surname)

Juana Guerrero

19a. Informant's Name/Relationship (Type, Print)

John Illenberger Brother in law 1742 Swinburne Ave. Crofton, MD 21114

20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Florida National Cem

Date

3/28/2007

20c. Location - City or Town, State

Bushnell, FL

21. Signature of Funeral Service Licensee



22. Name and Address of Facility

Hardesty Funeral Home, P.A.
12 Ridgely Ave. Annapolis, MD 21401

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Approximate Interval Between Onset and Death
YEARS

CORONARY ARTERY DISEASE

Due to (or as a consequence of):

ATRIAL FIBRILLATION

YEARS

b. Due to (or as a consequence of):

CHRONIC OBSTRUCTIVE PULMONARY DISEASE

YEARS

Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No

9 Unknown

23c. If yes, outcome pf pregnancy

1 Live birth 2 Fetal death 3 Ectopic pregnancy

4 Pregnant at time of death 5 Other (specify)

9 Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 Yes 2 No 3 Probably 4 Unknown

25. Was case referred to medical examiner?

1 Yes 2 No

26. Place of Death (Check only one)

Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)

27. Manner of Death

1 Natural

2 Accident

3 Suicide

4 Homicide

5 Pending investigation

6 Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 Yes 2 No

28d. Describe how injury occurred

29a. Certifier (Check only one)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier



29c. License number

D22856

29d. Date signed (Month, Day, Year)

March 21 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

LILIA CEBALLOS 7601 OSLER DRIVE TOWSON, MARYLAND 21204

31. Date filed (Month, Day, Year)

MAR 26 2007

32. Registrar's Signature



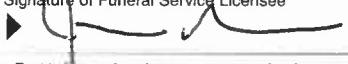
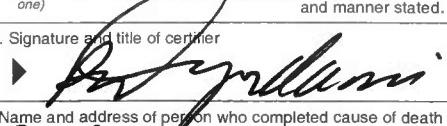
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 12153

1- For State Registrar

Physician /Medical Examiner		1. Decedent's Name (First, Middle, Last) THIRENA GREEN						2. Date of Death Month Month Day Year MARCH 27 2007		3. Time of Death 1:21PM ^M			
Funeral Director		4a. Facility Name (If not institution, give street and number) SOUTHERN MARYLAND HOSPITAL			4b. City, Town, or Location of Death CLINTON			4c. County of Death P.G.					
To Be Completed by Funeral Director		5. Social Security Number 577 76 6862		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 49 Yrs.		If Under 1 Year Months	If Under 24 Hrs. Hours	Min.	8. Date of Birth (Month, Day, Year) DEC 3 1957		9. Birthplace (State or Foreign Country) WASH. DC.	
To Be Completed by Physician/Medical Examiner		10a. State MD			10b. County P.G.		10c. City, Town or Location OXON HILL			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
To Be Completed by Physician/Medical Examiner		10e. Street and Number 547 WILSON BRIDGE DRIVE #A1				10f. Zip Code 20745			10g. Citizen of What Country? USA				
To Be Completed by Physician/Medical Examiner		11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: BLACK				
To Be Completed by Physician/Medical Examiner		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) SALES PERSON		16b. Kind of Business/Industry PVT.							
To Be Completed by Physician/Medical Examiner		17. Father's Name (First, Middle, Last) WINON JONES				18. Mother's Name (First, Middle, Maiden Surname) CATHERINE WRAN							
To Be Completed by Physician/Medical Examiner		19a. Informant's Name/Relationship (Type, Print) CARLEATA LEE/SISTER			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6803 SUMMIT CREEK DR. CLINTON, MD. 20735			19c. Date of Disposition HARMONY MEM PARK 4/05/07					
To Be Completed by Physician/Medical Examiner		20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) HARMONY MEM PARK			Date 4/05/07		20c. Location - City or Town, State LANDOVER, MD.			
To Be Completed by Physician/Medical Examiner		21. Signature of Funeral Service Licensee 			22. Name and Address of Facility WATSON F. H. 3435 14th ST., N.W. WASH. D.C. 20010								
To Be Completed by Physician/Medical Examiner		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last						<i>Diabetes mellitus</i> <i>Hypertension</i>			Approximate Interval Between Onset and Death Unknown		
To Be Completed by Physician/Medical Examiner		23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown						23c. If yes, outcome pf pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____ <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year		
To Be Completed by Physician/Medical Examiner		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Chronic renal Disease						23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown					
To Be Completed by Physician/Medical Examiner		25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)									
To Be Completed by Physician/Medical Examiner		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred			
To Be Completed by Physician/Medical Examiner		28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State)					
To Be Completed by Physician/Medical Examiner		29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.			29b. Signature and title of certifier 			29c. License number 50454		29d. Date signed (Month, Day, Year) March, 30, 07			
To Be Completed by Physician/Medical Examiner		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) A. YAZDANI M.D. 9801 Georgia Av. 3-41 Silver Spring MD 20902											
To Be Completed by Physician/Medical Examiner		31. Date filed (Month, Day, Year) APR 03 2007			32. Registrar's Signature 								

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 12455

1- For State Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Joseph Maurice Dickerson Godfrey							2. Date of Death Month Month Day Day Year March 31, 2007	3. Time of Death 10:05 A M				
	4a. Facility Name (If not institution, give street and number) 8519 Newark Road				4b. City, Town, or Location of Death Newark			4c. County of Death Worcester					
Funeral Director	5. Social Security Number 214-10-6088	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 91 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Nov. 18, 1915	9. Birthplace (State or Foreign Country) Maryland						
To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State MD 10b. County Worcester 10c. City, Town or Location Newark								10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				
	10e. Street and Number 8519 Newark Road				10f. Zip Code 21841			10g. Citizen of What Country? U.S.A.					
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: white			14. Race - American Indian, Black, White, etc. white					
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+)			16b. Kind of Business/Industry Press Operator							
	17. Father's Name (First, Middle, Last) George Elmer Bowers Godfrey				18. Mother's Name (First, Middle, Maiden Surname) Cora Mae Dickerson								
	19a. Informant's Name/Relationship (Type, Print) Ruth Marie Webb Godfrey (wife)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8519 Newark Road Newark, MD 21841										
Physician /Medical Examiner	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) Bowen Church Cemetery		20b. Place of Disposition (Name of cemetery, crematory or other place) Bowen Church Cemetery			Date Apr. 3, 2007	20c. Location - City or Town, State Newark, Maryland						
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee Amy Short-Jewell		22. Name and Address of Facility Short Funeral Home 13 East Grove St. Delmar, DE 19940			Approximate Interval Between Onset and Death 5 years							
	23a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.												
	Immediate Cause (Final disease or condition resulting in death) Lung Cancer complicated by Pneumonia (on the Chronic Obstructive Pulmonary Disease)												
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last 5 years												
	a. Due to (or as a consequence of): Lung Cancer complicated by Pneumonia (on the Chronic Obstructive Pulmonary Disease)												
	b. Due to (or as a consequence of): Chronic Obstructive Pulmonary Disease												
	c. Due to (or as a consequence of):												
	d. Due to (or as a consequence of):												
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year							
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Parkinsons Vertigo Disturbance								23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown				
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No			
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred						
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State)						
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								29b. Signature and title of certifier John Whittaker, MS				
	29c. License number DO053262								29d. Date signed (Month, Day, Year) 04-02-2007				
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) John Whittaker, MS								30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 305 10th Street Suite 105 Pocomoke, MD 21851 (410) 957-2112				
State Registrar	31. Date filed (Month, Day, Year) APR 03 2007		32. Registrar's Signature John B. Smith										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

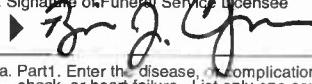
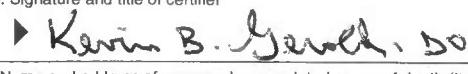
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007

12456

1- For State Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) DAVID HALL					2. Date of Death Month APRIL Day 01 Year 2007	3. Time of Death 12:00 PM									
	4a. Facility Name (If not institution, give street and number) JOHNS HOPKINS BAYVIEW MED CENTER		4b. City, Town, or Location of Death BALTIMORE MD			4c. County of Death BALTIMORE CITY										
Funeral Director	5. Social Security Number 052-32-3466	6. Sex M	7. Age (In yrs. last birthday) 66 Yrs.	If Under 1 Year Months 0	If Under 24 Hrs. Days 0	8. Date of Birth Month Day Year 4/6/1940	9. Birthplace (State or Foreign Country) NY									
To Be Completed by Funeral Director	10a. State MD		10b. County Anne Arundel	10c. City, Town or Location Annapolis				10d. Inside City Limits 1 Yes 2 No								
	10e. Street and Number 933 Ships Bell Ct.			10f. Zip Code 21401			10g. Citizen of What Country? USA									
	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: 1957-1960	13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No Specify:			14. Race - American Indian, Black, White, etc. White									
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 4 Paralegal	16b. Kind of Business/Industry Law												
	17. Father's Name (First, Middle, Last) Ralph L. Hall			18. Mother's Name (First, Middle, Maiden Surname) Hazel Johnson												
	19a. Informant's Name/Relationship (Type, Print) Nancy Ann Hall Wife			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 933 Ships Bell CT Annapolis, MD 21401												
Physician /Medical Examiner	20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Metro Crematory		Date 4/5/2007	20c. Location - City or Town, State Baltimore, MD										
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee 			22. Name and Address of Facility Hardesty Funeral Home, P.A. 12 Ridgely Ave. Annapolis, MD 21401												
	23a. Part I. Enter the disease, complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last															
	<table border="1"> <tr> <td>a. HYPOVOLMIC SHOCK Due to (or as a consequence of):</td> <td>Approximate Interval Between Onset and Death 1 HOUR</td> </tr> <tr> <td>b. ACUTE HEMORRHAGE Due to (or as a consequence of):</td> <td></td> </tr> <tr> <td>c. CAROTID-ESOPHAGEAL FISTULA Due to (or as a consequence of):</td> <td>2 DAYS</td> </tr> <tr> <td>d.</td> <td></td> </tr> </table>								a. HYPOVOLMIC SHOCK Due to (or as a consequence of):	Approximate Interval Between Onset and Death 1 HOUR	b. ACUTE HEMORRHAGE Due to (or as a consequence of):		c. CAROTID-ESOPHAGEAL FISTULA Due to (or as a consequence of):	2 DAYS	d.	
a. HYPOVOLMIC SHOCK Due to (or as a consequence of):	Approximate Interval Between Onset and Death 1 HOUR															
b. ACUTE HEMORRHAGE Due to (or as a consequence of):																
c. CAROTID-ESOPHAGEAL FISTULA Due to (or as a consequence of):	2 DAYS															
d.																
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown		23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (Specify) 9 Unknown			23d. Date of delivery Month Day Year										
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. LARYNGEAL CANCER LARYNGECTOMY															
	23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown															
	24a. Was an autopsy performed? 1 Yes 2 No				24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No											
	25. Was case referred to medical examiner? 1 Yes 2 No		26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)													
	27. Manner of Death 1 Natural 5 Pending investigation 2 Accident 6 Could not be determined 3 Suicide 4 Homicide		28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 Yes 2 No	28d. Describe how injury occurred										
			28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)											
	29a. Certifier (Check only one) 1 Certifying Physician 2 Medical Examiner		To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.													
	29b. Signature and title of certifier 		29c. License number H31298			29d. Date signed (Month, Day, Year) APRIL 01, 2007										
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KEVIN B. GEROW, JOHNS HOPKINS BAYVIEW MED CENTER, BALTIMORE, MD															
State Registrar	31. Date filed (Month, Day, Year) APR 03 2007		32. Registrar's Signature 													

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 12457

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Katherine R. Hodges						2. Date of Death Month Day Year March 30, 2007	3. Time of Death 12:10 A.M.	
	4a. Facility Name (If not institution, give street and number) 900 Cedar Heights Drive			4b. City, Town, or Location of Death Capitol Heights			4c. County of Death Prince George's		
Funeral Director	5. Social Security Number 577-30-4431	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 77 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) 11/25/29	9. Birthplace (State or Foreign Country) Chester, Pa.		
	Usual Residence of Decedent P.G.			10c. City, Town or Location Cedar Heights			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
To Be Completed by Funeral Director	10a. State Md.			10b. County P.G.			10e. Street and Number 900 Cedar Heights Drive	10f. Zip Code 20743	10g. Citizen of What Country? U.S.A.
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: 2 yrs.		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Black	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+)			16b. Kind of Business/Industry Registered Nurse		
	17. Father's Name (First, Middle, Last) Robert Atkinson				18. Mother's Name (First, Middle, Maiden Surname) Priscilla Stoney				
	19a. Informant's Name/Relationship (Type, Print) Maria L. Shannon/Daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 900 Cedar Heights Dr., Cedar Heights, Md. 20743				
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) Darry K. Scott			20b. Place of Disposition (Name of cemetery, crematory or other place) Arlington Nat'l. Cem.		Date 4/18/07	20c. Location - City or Town, State Ft. Myer, Virginia		
	21. Signature of Funeral Service Licensee Darry K. Scott				22. Name and Address of Facility H.S. Washington & Sons Co., Inc. 4925 Burroughs Ave., N.E., Washington, D.C. 20019				
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				Approximate Interval Between Onset and Death				
	<p>a. Acute Myocardial Infarction Due to (or as a consequence of):</p> <p>b. Hypertensive Heart Disease Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. </p>								
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year			
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown				
					<p>24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>				
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred		
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
	29b. Signature and title of certifier Ophelia Cumberbatch, M.D.				29c. License number D27577		29d. Date signed (Month, Day, Year) 4/2/07		
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ophelia Cumberbatch, M.D.				31. Date filed (Month, Day, Year) APR 03 2007				
					32. Registrar's Signature James D. Jones				

Division of Vital Records, P.O. Box 68760,

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or Item 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007

12458

1- For
State
Registrar

Physician /Medical Examiner		1. Decedent's Name (First, Middle, Last) ROLAND R. HOPKINS					2. Date of Death Month April Day 1 Year 2007		3. Time of Death 1717 M			
Funeral Director		4a. Facility Name (If not institution, give street and number) Memorial Hospital					4b. City, Town, or Location of Death Easton		4c. County of Death Talbot			
To Be Completed by Funeral Director		5. Social Security Number 216-18-8450		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 83	Yrs.	If Under 1 Year Months	If Under 24 Hrs. Hours	8. Date of Birth (Month, Day, Year) JUNE 14, 1923	9. Birthplace (State or Foreign Country) MARYLAND		
		Usual Residence of Decedent		10a. State MD		10b. County TALBOT	10c. City, Town or Location EASTON			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
		10e. Street and Number 504 BRIDGE ST.					10f. Zip Code 21601		10g. Citizen of What Country? USA			
		11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: WHITE		
		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) CONTRACTOR			16b. Kind of Business/Industry MASONRY				
		17. Father's Name (First, Middle, Last) CHARLIE HOPKINS					18. Mother's Name (First, Middle, Maiden Surname) LULA PERRY					
		19a. Informant's Name/Relationship (Type, Print) KATHERINE HOPKINS/WIFE					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 504 BRIDGE ST., EASTON, MD 21601					
		20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) OXFORD CEMETERY			Date 4/6/2007		20c. Location - City or Town, State OXFORD, MARYLAND			
		21. Signature of Funeral Service Licensee ► JOHN R. MERCERON					22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWMAN FUNERAL HOME PA 200 S. HARRISON ST EASTON, MD 21601					
		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)					Approximate Interval Between Onset and Death					
		a. Aspiration pneumonia Due to (or as a consequence of):										
		b. Dehydration Due to (or as a consequence of):										
		c. Dysphagia Due to (or as a consequence of):										
		d. Dementia										
		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____ <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year					
		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown					
		25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred				
				28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)						
		29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
		29b. Signature and title of certifier ► Harlan Sorenson, MD		29c. License number D0059762			29d. Date signed (Month, Day, Year) 4/21/07					
		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Harlan Sorenson, MD										
		31. Date filed (Month, Day, Year) APR 04 2007		32. Registrar's Signature ► [Signature]								

Hopkins, Roland
Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

+5

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

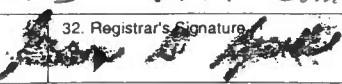
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2007 12459

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) BERNICE B. HANSON							2. Date of Death Month APRIL	Day 4	Year 2007	3. Time of Death M	
	4a. Facility Name (If not institution, give street and number) HEARTFIELDS AT EASTON							4b. City, Town, or Location of Death EASTON			4c. County of Death TALBOT	
Funeral Director	5. Social Security Number 577-40-4111		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 91 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	Hours	Min.	8. Date of Birth (Month, Day, Year) AUG 19 1915			9. Birthplace (State or Foreign Country) ILLINOIS
	Usual Residence of Decedent 10a. State MD		10b. County TALBOT		10c. City, Town or Location EASTON						10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
To Be Completed by Funeral Director	10e. Street and Number 700 PORT ST.				10f. Zip Code 21601			10g. Citizen of What Country? USA				
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: WHITE				
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) VOLUNTEER			16b. Kind of Business/Industry LOCAL GOVERNMENT				
	17. Father's Name (First, Middle, Last) FRANK BROWN					18. Mother's Name (First, Middle, Maiden Surname) BERNICE OSWALD						
	19a. Informant's Name/Relationship (Type, Print) SIGNE HANSON/DAUGHTER				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8821 TUCKAHOE RD., DENTON, MD 21629							
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) CHESAPEAKE CREMATION CTR			Date 4/6/2007	20c. Location - City or Town, State STEVENSVILLE, MD				
	21. Signature of Funeral Service Licensee Joseph M. Ostrowski C.F.S.J.											
	22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA 200 S. HARRISON ST EASTON, MD 21601											
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last											
	<p>a. <i>Organic Brain Disease</i> Due to (or as a consequence of):</p> <p>b. _____ Due to (or as a consequence of):</p> <p>c. _____ Due to (or as a consequence of):</p> <p>d. _____</p>											
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____ <input type="checkbox"/> Unknown							23d. Date of delivery Month Day Year		
Medical Certification: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.											
	23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown											
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No									
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) ASSISTED LIVING HOSPICE									
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred LIVING HOSPICE					
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)									
	29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29c. License number 20040274									
	29b. Signature and title of certifier J. Allen Welb. M.D.		29d. Date signed (Month, Day, Year) 4/6/2007									
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) J. Allen Welb. M.D. - 8519 Commerce Dr. Suite 106, EASTON, MD 21601											
	31. Date filed (Month, Day, Year) APR 9 2007											
	32. Registrar's Signature 											

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene
Certificate of Death

Reg. No. 2007 12460

1- For State Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Adelean Hinks				2. Date of Death Month April Day 2 Year 2007		3. Time of Death 18 32PM	
	4a. Facility Name (If not institution, give street and number) The Johns Hopkins Hospital		4b. City, Town, or Location of Death Baltimore City		4c. County of Death Baltimore			
Funeral Director	5. Social Security Number 219-03-5904	6. Sex 1 □ M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 87 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days Hours Min.	8. Date of Birth (Month, Day, Year) 12/01/1919	9. Birthplace (State or Foreign Country) Virginia	
	Usual Residence of Decedent 10a. State MD		10b. County Somerset		10c. City, Town or Location Upper Fairmount		10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 □ No	
To Be Completed by Funeral Director	10e. Street and Number 8288 Clinton Bozman Road			10f. Zip Code 21867		10g. Citizen of What Country? USA		
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: White		14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) none		16b. Kind of Business/Industry Director of Elections		State of Maryland	
	17. Father's Name (First, Middle, Last) Elmer Catlin			18. Mother's Name (First, Middle, Maiden Surname) Keturah Catlin				
	19a. Informant's Name/Relationship (Type, Print) Joseph J. Hinks, Jr./son			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 32053 Gordy Road, Laurel, DE 19956				
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) Hinman Funeral Home		20b. Place of Disposition (Name of cemetery, crematory or other place) Beechwood Cemetery		Date 04/07/2007	20c. Location - City or Town, State Princess Anne, MD		
	21. Signature of Funeral Service Licensee James L. Hanks MO0295							
	22. Name and Address of Facility Hinman Funeral Home 11673 Somerset Ave., Princess Anne, MD 21853							
	23a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. a. Immediate Cause (Final disease or condition resulting in death) cardiac arrhythmia Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Approximate Interval Between Onset and Death 20 minutes							
Physician /Medical Examiner	23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome pf pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year			
Medical Certification: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. hypertension							
	23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown							
	24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No							
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No							
	26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide							
	28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? M 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No							
	28d. Describe how injury occurred 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)							
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
	29b. Signature and title of certifier Kishan Baranano MD, PhD 29c. License number RES-000 29d. Date signed (Month, Day, Year) April 2 2007							
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kishan Baranano 600 N. Wolfe St Baltimore MD 21287							
State Registrar	31. Date filed (Month, Day, Year) APR 06 2007		32. Registrar's Signature Kishan Baranano					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2007 12461

1- For
State
RegistrarPhysician
/Medical
ExaminerFuneral
Director

To Be Completed by Funeral Director

1. Decedent's Name (First, Middle, Last)

Janie Sara Harrington

2. Date of Death

Month Day Year

3. Time of Death

April 1, 2007 2:50 AM

4a. Facility Name (If not institution, give street and number)

Salisbury Rehab & Nursing Ctr.

4b. City, Town, or Location of Death

Salisbury

4c. County of Death

Wicomico

5. Social Security Number

214-10-7842

6. Sex

 M F7. Age (In yrs. ~~last~~ birthday)

97

Yrs.

If Under 1 Year

If Under 24 Hrs.

8. Date of Birth

(Month, Day, Year)

Month Day Year

5/16/1909

Time of Death

2:50 AM

Usual Residence of Decedent

10a. State

10b. County

10c. City, Town or Location

Maryland

Wicomico

Salisbury

10d. Inside City Limits

 Yes No

10e. Street and Number

200 Civic Ave.

10f. Zip Code

21804

10g. Citizen of What Country?

USA

11. Marital Status

 Never Married Married
 Widowed Divorced

12. Was Decedent Ever in U.S. Armed Forces?

 Yes No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

 Yes No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
3College (1-4 or 5+)
-

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Seamstress

16b. Kind of Business/Industry

Shirt Factory

17. Father's Name (First, Middle, Last)

Minos Phippin

18. Mother's Name (First, Middle, Maiden Surname)

Viola (unknown)

19a. Informant's Name/Relationship (Type, Print)

Gilbert Disharoon/nephew

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

30570 Waycroft Dr., Salisbury, MD 21804

20a. Method of Disposition

 Burial Cremation Removal from State
 Donation Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Wicomico Memorial Park

Date

4/4/07

20c. Location - City or Town, State

Salisbury, MD

21. Signature of Funeral Service Licensee

WR William CFS

22. Name and Address of Facility

Holloway Funeral Home Professional Association
501 Snow Hill Rd., Salisbury, MD 21804

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Approximate Interval Between Onset and Death

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

a. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

days

years

years

years

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

 Yes No9 Unknown

23c. If yes, outcome of pregnancy

 Live birth Fetal death
 Pregnant at time of death Other (specify)9 Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

 Yes No Probably Unknown

25. Was case referred to medical examiner?

 Yes No

Hospital:

1 Inpatient 2 ER/Outpatient 3 DOA Other 4 Nursing Home 5 Residence 6 Other (Specify)

27. Manner of Death

1 Natural2 Accident3 Suicide4 Homicide5 Pending investigation6 Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

M

1 Yes 2 No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

William H. Robins, M.D.

29c. License number

029389

29d. Date signed (Month, Day, Year)

4/2/07

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

William H. Robins, M.D. 200 Civic Ave, Salisbury, MD 21804

31. Date filed (Month, Day, Year)

APR 05 2007

32. Registrar's Signature

Janie Sara Harrington

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 12462

1 - For State Registrar

Physician /Medical Examiner

Funeral Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
 Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year				3. Time of Death	
BETTY ANN HORSMAN		April 1 4 2007				0110 M	
4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of Death				4c. County of Death	
Peninsula Regional Medical Center		Salisbury				Wicomico	
5. Social Security Number		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 81 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth Month Day Year	9. Birthplace (State or Foreign Country) OHIO
10a. State MD		10b. County WICOMICO		10c. City, Town or Location SALISBURY			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
10e. Street and Number 611 TRESSLER DRIVE			10f. Zip Code 21801			10g. Citizen of What Country? USA	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: WHITE
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) HOMEMAKER		16b. Kind of Business/Industry OWNED HOME			
17. Father's Name (First, Middle, Last) DAN BARTLETT				18. Mother's Name (First, Middle, Maiden Surname) MARGARET SCHMIDT			
19a. Informant's Name/Relationship (Type, Print) BECKY JOSEPH DAUGHTER			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 31873 GORDY RD LAUREL, DE 19856				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) BIVALE CEMETERY		20b. Place of Disposition (Name of cemetery, crematory or other place)		Date 4-8-07	20c. Location - City or Town, State BIVALE, MD		
21. Signature of Funeral Service Licensee Clyde J. Schmitz MORT			22. Name and Address of Facility MESICK FUNERAL HOME #10 BOX 61 BIVALE, MD 21814				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. ATHEROSCLEROTIC CARDIOPULMONARY DISEASE Due to (or as a consequence of): b. _____ Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____							
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____					23d. Date of delivery Month Day Year
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. TYPE 2 DIABETES HYPERTENSION URINARY TRACT INFECTION							
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA		Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) _____		26. Place of Death Check only one <input type="checkbox"/> At home <input type="checkbox"/> Farm <input type="checkbox"/> Street <input type="checkbox"/> Factory <input type="checkbox"/> Office <input type="checkbox"/> Building, etc. (Specify) _____	
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred	
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)					
29b. Signature and title of certifier M. THIANNARAKOMMA, MD		29c. License number D-0060515			29d. Date signed (Month, Day, Year) 4/4/07		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M. THIANNARAKOMMA, MD 614 B EASTERN SHORE DR, SALISBURY MD 21804							
31. Date filed (Month Day Year) APR 04 2007		32. Registrar's Signature Beverly B. Spangler					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 12463

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Jacqueline Marion Innamorato				2. Date of Death Month April Day 3 Year 2007	3. Time of Death 4:50A M	
	4a. Facility Name (If not institution, give street and number) Calvert Memorial Hospital		4b. City, Town, or Location of Death Prince Frederick		4c. County of Death Calvert		
Funeral Director	5. Social Security Number 577-20-7861	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 85 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days Hours Min.	8. Date of Birth (Month, Day, Year) Aug. 4, 1921	9. Birthplace (State or Foreign Country) New Hampshire
	Usual Residence of Decedent 10a. State Virginia 10b. County Stafford				10c. City, Town or Location Fredericksburg		
To Be Completed by Funeral Director	10e. Street and Number 504 Jett St.			10f. Zip Code 22405		10g. Citizen of What Country? USA	
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: 1943-1945	13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	14. Race - American Indian, Black, White, etc. Specify: White			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 2 yrs.		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Housewife	16b. Kind of Business/Industry At Home			
	17. Father's Name (First, Middle, Last) Frank Alton Varney			18. Mother's Name (First, Middle, Maiden Surname) Marion Partridge			
	19a. Informant's Name/Relationship (Type, Print) Daughter Jeannette L. Innamorato-Episcopo			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 504 Jett St. Frederickburg, VA. 22405			
Physician /Medical Examiner	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <i>Kalas Crematory</i>	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date 4/4/07	20c. Location - City or Town, State Edgewater, MD.			
Medical Certification: To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee <i>Kalas</i>			22. Name and Address of Facility Geo. P. Kalas Funeral Home 6160 Oxon Hill Rd. Oxon Hill, Md. 20745			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.						
	Immediate Cause (Final disease or condition resulting in death) SEPSIS						
	Approximate Interval Between Onset and Death						
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last						
	<p>a. Due to (or as a consequence of): Aspiration</p> <p>b. Due to (or as a consequence of): Pneumonia</p> <p>c. Due to (or as a consequence of):</p> <p>d. Due to (or as a consequence of):</p>						
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown			23c. If yes, outcome pf pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____			
				23d. Date of delivery Month Day Year			
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. End stage Dementia Atherosclerotic Cardiovascular disease						
	23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown						
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No			
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide			28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred
				28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)
	29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.						
	29b. Signature and title of certifier <i>Leyla C. Surana</i>			29c. License number D 50653		29d. Date signed (Month, Day, Year) 4-3-2007	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5851 - Deale Churchton			31. Date filed (Month, Day, Year) APR 04 2007		32. Registrar's Signature <i>S. Surana</i>	
State Registrar							

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

ck (12)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2007 121:64

1- For
State
RegistrarPhysician
/Medical
Examiner

		1. Decedent's Name (First, Middle, Last) Miriam Celeste Jackson				2. Date of Death Month MAY Day 30 Year 2007	3. Time of Death 6:45 A M	
		4a. Facility Name (If not institution, give street and number) Doctor's Community Hospital		4b. City, Town, or Location of Death Lanham		4c. County of Death Prince Georges		
Funeral Director		5. Social Security Number 578-56-9902	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 64 Yrs.	If Under 1 Year Months 0	If Under 24 Hrs. Days 0	8. Date of Birth (Month, Day, Year) July 31, 1942	9. Birthplace (State or Foreign Country) Washington, D.C.
To Be Completed by Funeral Director		Usual Residence of Decedent 10a. State Maryland 10b. County Prince Georges 10c. City, Town or Location Mitchellville				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
		10e. Street and Number 10108 Juniper Dr.		10f. Zip Code 20721		10g. Citizen of What Country? United States		
		11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	14. Race - American Indian, Black, White, etc. Specify: Black			
		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Budget Analyst		16b. Kind of Business/Industry Federal Government		
		17. Father's Name (First, Middle, Last) David Georges			18. Mother's Name (First, Middle, Maiden Surname) Agnes Curtis			
		19a. Informant's Name/Relationship (Type, Print) John F. Jackson, Jr. /Son		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 811 Arbor Park Place Mitchellville, Md. 20721				
		20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <i>Katherine Lange MD 1085</i>		20b. Place of Disposition (Name of cemetery, crematory or other place) Resurrection		Date April 5, 2007	20c. Location - City or Town, State Clinton, Md.	
		21. Signature of Funeral Service Licensee <i>Katherine Lange MD 1085</i>		22. Name and Address of Facility Alexander S. Pope, P.A. 5538 Marlboro Pike/Forestville, Md. 20747				
		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Breast CANCER				Approximate Interval Between Onset and Death		
		a. Due to (or as a consequence of): DISSEMINATED METASTASIS						
		b. Due to (or as a consequence of): DIABETES MELLUS						
		c. Due to (or as a consequence of): DIABETES MELLUS						
		d. Due to (or as a consequence of):						
		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome pf pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input checked="" type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year		
		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
		25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year) M 28b. Time of Injury M 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
				28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State) 20720		
		29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29c. License number D58182 29d. Date signed (Month, Day, Year) 3-30-2007		
		29b. Signature and title of certifier <i>Cecil George M.D.</i>						
		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Cecil George M.D. 1525 GREENWAY CENTER DRIVE SUITE 113 GREENBELT MD 20770						
State Registrar		31. Date filed (Month, Day, Year) APR 03 2007		32. Registrar's Signature: <i>D. Smith</i>				

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
 Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

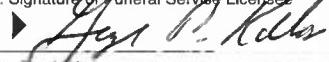
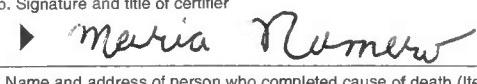
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2007 12465

1- For State Registrar

Physician /Medical Examiner Funeral Director To Be Completed by Funeral Director Physician /Medical Examiner Medical Certification: To Be Completed by Physician/Medical Examiner	<p>1. Decedent's Name (First, Middle, Last) Gloria J. Kurtz</p> <p>2. Date of Death Month March Day 29 Year 2007</p> <p>3. Time of Death 01:00 A M</p> <p>4a. Facility Name (If not institution, give street and number) La Casa Assisted Living</p> <p>4b. City, Town, or Location of Death Annapolis</p> <p>4c. County of Death Anne Arundel</p> <p>5. Social Security Number 185-14-6011</p> <p>6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F</p> <p>7. Age (In yrs. last birthday) Yrs. 85</p> <p>If Under 1 Year Months Days Hours Min.</p> <p>8. Date of Birth (Month, Day, Year) 03/28/1922</p> <p>9. Birthplace (State or Foreign Country) Pennsylvania</p> <p>Usual Residence of Decedent</p> <p>10a. State Maryland</p> <p>10b. County Anne Arundel</p> <p>10c. City, Town or Location Annapolis</p> <p>10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>10e. Street and Number 710 Ballast Way</p> <p>10f. Zip Code 21401</p> <p>10g. Citizen of What Country? United States</p> <p>11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced</p> <p>12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: If Yes, Give Year or Dates:</p> <p>13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: White</p> <p>15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12</p> <p>16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Computer Systems Analyst</p> <p>16b. Kind of Business/Industry Federal Government</p> <p>17. Father's Name (First, Middle, Last) George Louis Heller</p> <p>18. Mother's Name (First, Middle, Maiden Surname) Betty Galbraith</p> <p>19a. Informant's Name/Relationship (Type. Print) Sara Kurtz/Daughter</p> <p>19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1318 Bay Ridge Avenue, Annapolis, Maryland 21403</p> <p>20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) Kalas Crematory</p> <p>20b. Place of Disposition (Name of cemetery, crematory or other place) Kalas Crematory</p> <p>Date 03/30/2007</p> <p>20c. Location - City or Town, State Edgewater, Maryland</p> <p>21. Signature of Funeral Service Licensee </p> <p>22. Name and Address of Facility George P. Kalas Funeral Home, P.A. 2973 Solomons Island Rd., Edgewater, MD 21037</p> <p>23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.</p> <p>Immediate Cause (Final disease or condition resulting in death)</p> <p>Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</p> <p>a. Congestive Heart Failure Due to (or as a consequence of):</p> <p>b. Renal Failure Due to (or as a consequence of):</p> <p>c. Metastatic Bone Cancer Due to (or as a consequence of):</p> <p>d. _____</p> <p>Approximate Interval Between Onset and Death</p> <p>IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown</p> <p>23c. If yes, outcome pf pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown</p> <p>23d. Date of delivery Month Day Year</p> <p>Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.</p> <p>23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown</p> <p>24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) Assisted Living</p> <p>27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide</p> <p>28a. Date of Injury (Month, Day Year) 28b. Time of Injury M</p> <p>28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>28d. Describe how injury occurred</p> <p>28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)</p> <p>28f. Location (Street and Number or Rural Route Number, City or Town, State)</p> <p>29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.</p> <p>29b. Signature and title of certifier </p> <p>29c. License number D052023</p> <p>29d. Date signed (Month, Day, Year) 03/29/2007</p> <p>30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Maria Romero, M.D., 122 Defense Highway, Suite 200, Annapolis, Maryland 21401</p> <p>31. Date filed (Month, Day, Year) APR 02 2007</p> <p>32. Registrar's Signature </p>			
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Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2007 12466

1- For
State
Registrar

Physician
/Medical
Examiner

Funeral
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

1. Decedent's Name (First, Middle, Last)		ARNOLD KALMBACH				2. Date of Death Month April Day 3 Year 2007	3. Time of Death 11:45 P M
4a. Facility Name (If not institution, give street and number)		Frederick Memorial Hospital				4b. City, Town, or Location of Death Frederick	4c. County of Death Frederick
5. Social Security Number		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 72 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) October 16, 1934	9. Birthplace (State or Foreign Country) Romania
Usual Residence of Decedent		10a. State Maryland 10b. County Frederick				10c. City, Town or Location Thurmont	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No							
10e. Street and Number 127 Victor Drive				10f. Zip Code 21788		10g. Citizen of What Country? USA	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: white	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Master Carpenter		16b. Kind of Business/Industry Carpentry	
17. Father's Name (First, Middle, Last) Emanuel Kalmbach				18. Mother's Name (First, Middle, Maiden Surname) Katrina Roof			
19a. Informant's Name/Relationship (Type, Print) Elisabeth Kalmbach - wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 127 Victor Drive, Thurmont, Maryland 21788			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Blue Ridge Cemetery		Date 4-7-2007	20c. Location - City or Town, State Thurmont, Maryland
21. Signature of Funeral Service Licensee Sharon Camille Cline				22. Name and Address of Facility Stauffer Funeral Home 1621 Opossumtown Pike, Frederick, Maryland 21702			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)				23b. Due to (or as a consequence of): Renal Cell Carcinoma, metastas. Approximate Interval Between Onset and Death 1 week			
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				23c. Due to (or as a consequence of): Metabolic acidosis 2 weeks			
23d. If Female: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown				23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify)			
23d. Date of delivery Month Day Year				23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DVT				23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Determined <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred	
		28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29c. License number D175479				29d. Date signed (Month, Day, Year) 4/4/07	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) William F. Harper		180 Thomas Johnson Drive, Frederick, Maryland 21702					
31. Date filed (Month, Day, Year) APR 05 2007		32. Registrar's Signature Suzanne B. Aponte					

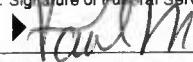
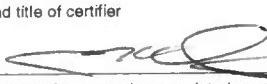
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 12467

1 - For
State
Registrar

Physician / Medical Examiner	1. Decedent's Name (First, Middle, Last) MELVIN DAVID KOLB							2. Date of Death Month APRIL Day 9 Year 2007	3. Time of Death 12:00 P M
	4a. Facility Name (If not institution, give street and number) JULIA MANOR HEALTH CARE CENTER				4b. City, Town, or Location of Death HAGERSTOWN			4c. County of Death WASHINGTON	
Funeral Director	5. Social Security Number 216-03-0085	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 92 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) NOV. 20, 1914	9. Birthplace (State or Foreign Country) WEST VIRGINIA		
To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State MARYLAND 10b. County WASHINGTON 10c. City, Town or Location BOONSBORO 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
	10e. Street and Number 17903 MEADE COURT				10f. Zip Code 21713			10g. Citizen of What Country? U.S.A.	
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: WHITE	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) IRON WORKER				16b. Kind of Business/Industry CONSTRUCTION	
	17. Father's Name (First, Middle, Last) GEORGE KOLB					18. Mother's Name (First, Middle, Maiden Surname) MABEL (UNKNOWN)			
	19a. Informant's Name/Relationship (Type, Print) PAUL E. LEWIS/STEP SON					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17218 DICKENSON LANE, FAIRPLAY, MARYLAND 21733			
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) SMITHSBURG CREMATORIAL			Date 4/10/2007	20c. Location - City or Town, State SMITHSBURG, MARYLAND		
	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility BAST FUNERAL HOME			23. Approximate Interval Between Onset and Death 6M			
Physician / Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								
	<p>a. <u>Congestive Heart Failure</u> Due to (or as a consequence of):</p> <p>b. <u>Renal Failure</u> Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. </p>								
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year			
Medical Certification: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown			
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			23f. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
	27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	28c. Injury at Work? M <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred			
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29c. License number PS2323			29d. Date signed (Month, Day, Year) 04-09-2007			
	29b. Signature and title of certifier 		29c. License number PS2323			29d. Date signed (Month, Day, Year) 04-09-2007			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Khalid M. Waseem, M.D.		31. Date filled (Month, Day, Year) APR 10 2007			32. Registrar's Signature 			

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

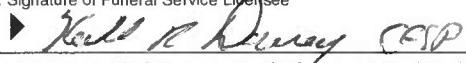
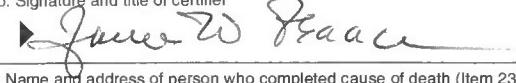
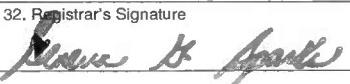
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2007 12468

1- For
State
Registrar

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Bruce Kent							2. Date of Death Month 03 Day 30 Year 07	3. Time of Death 1705 M
	4a. Facility Name (If not institution, give street and number) Coastal Hospice at the Lake			4b. City, Town, or Location of Death Salisbury			4c. County of Death Wicomico		
Funeral Director	5. Social Security Number 231-42-2407	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 92 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) 3/13/1915	9. Birthplace (State or Foreign Country) Virginia		
To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State Maryland 10b. County Wicomico 10c. City, Town or Location Salisbury							10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
	10e. Street and Number 1109 S. Schumaker Drive			10f. Zip Code 21804			10g. Citizen of What Country? USA		
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No.) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: white		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) School Administrator			16b. Kind of Business/Industry Education		
	17. Father's Name (First, Middle, Last) Robert Lee Kent					18. Mother's Name (First, Middle, Maiden Surname) Rosa Martin			
	19a. Informant's Name/Relationship (Type, Print) Mary K. Feffer/daughter			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12631 Whisper Trace Dr., Ocean City, MD 21842					
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Salisbury Crematory			Date 4/2/07	20c. Location - City or Town, State Salisbury, MD	
	21. Signature of Funeral Service Licensee 			22. Name and Address of Facility Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804					
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Secondary list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death
	<p>a. Due to (or as a consequence of): FAILURE TO THRIVE</p> <p>b. Due to (or as a consequence of): CORONARY ARTERY DISEASE.</p> <p>c. Due to (or as a consequence of):</p> <p>d. Due to (or as a consequence of):</p>								
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown			23c. If yes, outcome pf pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____			23d. Date of delivery Month Day Year		
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ULCERATIVE COLITIS -								23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide			28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred		
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)		
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
	29b. Signature and title of certifier 			29c. License number 714256			29d. Date signed (Month, Day, Year) March 31, 2007		
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) THE LAKE, DEERSHEAD HOSPITAL, SALISBURY MD 21801 -								
State Registrar	31. Date filed (Month, Day, Year) APR 03 2007		32. Registrar's Signature 						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. **2007 121659**

1 - For State Registrar

Physician /Medical Examiner

Funeral Director

To Be Completed by Funeral Director

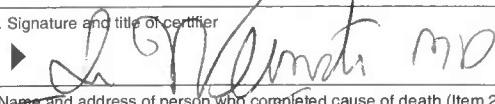
Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year		3. Time of Death	
Calvin Elwood Lauder		March 31, 2007		11:17A^M	
4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of Death		4c. County of Death	
Anne Arundel Medical Center		Annapolis		Anne Arundel	
5. Social Security Number	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 82 Yrs.	If Under 1 Year Months Days Hours Min.	8. Date of Birth (Month, Day, Year) 02/25/1925	9. Birthplace (State or Foreign Country) Maryland
Usual Residence of Decedent		10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Maryland Anne Arundel		Annapolis			
10e. Street and Number 712 Sydney Terrace		10f. Zip Code 21401		10g. Citizen of What Country? United States	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: 1943-46		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Educational Administrator		16b. Kind of Business/Industry Public Education	
17. Father's Name (First, Middle, Last) David Lauder		18. Mother's Name (First, Middle, Maiden Surname) Florence Viola Russell			
19a. Informant's Name/Relationship (Type, Print) Beverly V. Lauder / Wife		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 712 Sydney Terr. Annapolis, Maryland 21401			
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) Kalas Crematory		20b. Place of Disposition (Name of cemetery, crematory or other place)		Date 04/01/2007	20c. Location - City or Town, State Edgewater, Maryland
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD, 21037			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		Approximate Interval Between Onset and Death Lung Cancer			
a. Due to (or as a consequence of):					
b. Due to (or as a consequence of):					
c. Due to (or as a consequence of):					
d. Due to (or as a consequence of):					
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown <input type="checkbox"/> Other (Specify) _____		23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
				24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred
		28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier 		29c. License number 1038445		29d. Date signed (Month, Day, Year) 03/31/2007	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Eric Wainstein 600 Ridgely Dr, Annapolis, MD					
31. Date filed (Month, Day, Year) APR 02 2007		32. Registrar's Signature 			

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 12470

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) William Lawrence							2. Date of Death Month March	Day 27	Year 2007	3. Time of Death 1:25 A M		
	4a. Facility Name (If not institution, give street and number) Prince George's Hospital Center				4b. City, Town, or Location of Death Hyattsville			4c. County of Death Prince George's					
Funeral Director	5. Social Security Number 234-64-6700	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 65 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) June 26 1941	9. Birthplace (State or Foreign Country) North Carolina						
	Usual Residence of Decedent 10a. State NC 10b. County Martin				10c. City, Town or Location Robersonville			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
10e. Street and Number 302 Wynnlyn Avenue				10f. Zip Code 27871			10g. Citizen of What Country? United States						
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: 11			13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: Black					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Fork Lift Operator			16b. Kind of Business/Industry Private						
17. Father's Name (First, Middle, Last) Cleve Lawrence				18. Mother's Name (First, Middle, Maiden Surname) Sophia Spruill									
19a. Informant's Name/Relationship (Type, Print) Barbara Lawrence/Wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 302 Wynnlyn Avenue/Post Office Box 1593 Rebersonville, North Carolina 27871			20c. Location - City or Town, State Hamilton, NC						
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) Hamilton Memorial				20b. Place of Disposition (Name of cemetery, crematory or other place) April 10, 07									
21. Signature of Funeral Service Licensee Charles E. Young				22. Name and Address of Facility Pope Funeral Homes, P.A. 5538 Marlboro Pike, Forestville, Maryland 20747									
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last										Approximate Interval Between Onset and Death			
<p>a. Pneumonia Due to (or as a consequence of):</p> <p>b. Pseudomonas Infection Due to (or as a consequence of):</p> <p>c. _____ Due to (or as a consequence of):</p> <p>d. _____</p>													
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Unknown						23d. Date of delivery Month Day Year					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Cerebral Infarction, Anoxic Encephalopathy							23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown						
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.													
29b. Signature and title of certifier Lester Miles MD				29c. License number D0026024			29d. Date signed (Month, Day, Year) March 30, 2007						
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Lester Miles, MD 6490 Landover Road, Landover, MD 20785													
31. Date filed (Month, Day, Year) APR 03 2007		32. Registrar's Signature Robert D. Apfel											

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial service.

Medical Certification; To Be Completed by Physician/Medical Examiner

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or items 23a or 28a show any injury or other traumatic event, the Medical Examiner must be notified once.

cf (3)

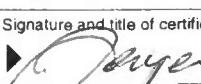
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene
Certificate of Death

2007 12471

Reg. No.

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Richard Arlington Lawrence							2. Date of Death Month April Day 3 Year 2007	3. Time of Death 23:51 PM	
	4a. Facility Name (If not institution, give street and number) Union Hospital of Cecil County			4b. City, Town, or Location of Death Elkton			4c. County of Death Cecil			
Funeral Director	5. Social Security Number 422-34-3929	6. Sex M	7. Age (In yrs. last birthday) 75 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) Jan. 5, 1932	9. Birthplace (State or Foreign Country) Alabama			
Usual Residence of Decedent 10a. State Maryland 10b. County Cecil 10c. City, Town or Location North East 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No										
10e. Street and Number 111 Red Toad Road				10f. Zip Code 21901			10g. Citizen of What Country? United States			
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: US Army			13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: White			14. Race - American Indian, Black, White, etc. White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 2			16b. Kind of Business/Industry Machinist			Manufacturing		
17. Father's Name (First, Middle, Last) Arlie Lawrence					18. Mother's Name (First, Middle, Maiden Surname) Eunice Bradley					
19a. Informant's Name/Relationship (Type, Print) Michael T. Lawrence / Grandson					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 685 Telegraph Road, Rising Sun, Maryland 21911					
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) Mayerdale Crematory					20b. Place of Disposition (Name of cemetery, crematory or other place) Mayerdale Crematory			Date April 5, 2007	20c. Location - City or Town, State Newark, Delaware	
21. Signature of Funeral Service Licensee 										
22. Name and Address of Facility Crouch Funeral Home 127 South Main Street, North East, Maryland 21901										
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Acute Respiratory Failure Due to (or as a consequence of) Secondary to Bronchopneumonia Due to (or as a consequence of) Chronic Lymphocytic Leukemia Due to (or as a consequence of) Thrombocytopenic Secondary 'C' Approximate Interval Between Onset and Death 8 hrs - 2 wks approx - 7 years approx - 2 wks -										
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 4 <input type="checkbox"/> Pregnant at time of death 9 <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Acute Myocardial Infarction - non Congestive Heart Failure										
23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown										
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No					26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined					28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
29b. Signature and title of certifier 					29c. License number D22307			29d. Date signed (Month, Day, Year) April 4, 2007		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JAYANTILALK PATEL MD 123 Singletary Ave, ELKTON MD 21921										
31. Date filed (Month, Day, Year) APR 5 2007		32. Registrar's Signature Patricia A. Pate								

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit document.

Medical Certification: To Be Completed by Physician/Medical Examiner

Lawrence, Richard A
Baltimore, Maryland 21215-0036
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a show any injury or other traumatic event, the Medical Examiner must be notified at once.

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene
Certificate of Death

Reg. No. 2007 12472

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Cynthia Ann Lokey						2. Date of Death Month April Day 02 Year 2007			3. Time of Death M 1953	
	4a. Facility Name (If not institution, give street and number) Peninsula Regional Medical Center			4b. City, Town, or Location of Death Salisbury			4c. County of Death Wicomico				
Funeral Director	5. Social Security Number 221-24-9328		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 70 Yrs.	If Under 1 Year Months		If Under 24 Hrs. Hours		8. Date of Birth (Month, Day, Year) 2/4/1937	9. Birthplace (State or Foreign Country) Delaware	
	Usual Residence of Decedent 10a. State Tennessee		10b. County Cumberland		10c. City, Town or Location Crossville					10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
To Be Completed by Funeral Director	10e. Street and Number 175 Locksley Circle				10f. Zip Code 38555			10g. Citizen of What Country? USA			
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced				12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: white
Physician /Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Administrative Assistant			16b. Kind of Business/Industry Holly Center			
	17. Father's Name (First, Middle, Last) alan G.W. Knowles				18. Mother's Name (First, Middle, Maiden Surname) Lee Ila Eller						
Medical Certification: To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Gilbert Lee Lokey/husband				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 175 Locksley Circle, Crossville, TN 38555						
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) Parsons Cemetery				20b. Place of Disposition (Name of cemetery, crematory or other place) Parsons Cemetery			Date 4/7/07	20c. Location - City or Town, State Salisbury, MD		
Medical Certification: To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee David A. Thompson				22. Name and Address of Facility Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804						
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)				23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Dabetes mellitus Prednisone usage			Approximate Interval Between Onset and Death			
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				a. Due to (or as a consequence of): Pneumonia							
				b. Due to (or as a consequence of):							
				c. Due to (or as a consequence of):							
				d. Due to (or as a consequence of):							
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome pf pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown						23d. Date of delivery Month Day Year			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
								24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA						Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred				
		28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								29d. Date signed (Month, Day, Year) 4/4/07			
29b. Signature and title of certifier J. A. Cockey, M.D.		29c. License number 00025674									
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) J. A. Cockey, M.D. 1346 S. Division St., Salisbury, Md. 21804											
31. Date filed (Month, Day, Year) APR 05 2007		32. Registrar's Signature Karen B. Smith									

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transit

Baltimore, Maryland 21215-0036
 Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
 Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 12473

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Matthew James Mills							2. Date of Death Month Day Year 3 26 07	3. Time of Death 4:10PM		
	4a. Facility Name (If not institution, give street and number) AAMC			4b. City, Town, or Location of Death Annapolis			4c. County of Death Anne Arundel				
Funeral Director	5. Social Security Number NA	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) Yrs. —	If Under 1 Year Months 4	If Under 24 Hrs. Days 4	8. Date of Birth (Month, Day, Year) 3-22-07	9. Birthplace (State or Foreign Country) MD				
	10a. State MD			10b. County Anne Arundel			10c. City, Town or Location Crofton				
10e. Street and Number 1858 Sharwood Pl				10f. Zip Code 21114			10g. Citizen of What Country? USA				
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: —			13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: —			14. Race - American Indian, Black, White, etc. Specify: white			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) —				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) N/A			16b. Kind of Business/Industry NA				
17. Father's Name (First, Middle, Last) Matthew Mackenzie Mills				18. Mother's Name (First, Middle, Maiden Surname) Natalie Alice Springer Mills							
19a. Informant's Name/Relationship (Type, Print) Natalie Mills /mother				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1858 Sharwood Pl Crofton, MD 21114							
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) ► <i>Burial</i>				20b. Place of Disposition (Name of cemetery, crematory or other place) Metro Crematory			Date 3/31/2007	20c. Location - City or Town, State Baltimore, MD			
21. Signature of Funeral Service Licensee ► <i>Suzanne Rindfleisch</i>				22. Name and Address of Facility Hardesty Funeral Home, P.A. 12 Ridgely Ave. Annapolis, MD 21401							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. hyperkalemia Due to (or as a consequence of): b. extensive intraventricular hemorrhage Due to (or as a consequence of): c. extreme hypotension Due to (or as a consequence of): d. —									Approximate Interval Between Onset and Death 2 days 2 days 4 days		
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown							23d. Date of delivery Month Day Year		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
									24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No									26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury		28c. Injury at Work? M <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)											
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									29c. License number H 42733	29d. Date signed (Month, Day, Year) March 27, 2007	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Suzanne Rindfleisch 2001 Medical Pkwy Annapolis MD											
31. Date filed (Month, Day, Year) APR 03 2007				32. Registrar's Signature Suzanne Rindfleisch							

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transit

Medical Certification; To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2007 12474

1. For State
Registrar**Physician/
Medical Examiner**

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death 1614 hrs
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Kevin Morris

March 30, 2007

4a. Facility Name (if not institution, give street and number) Prince Georges Hospital Center	4b. City, Town, or Location of Death Cheverly	4c. County of Death Prince George's
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10/07/1982

Maryland

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 12675

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Lillian Ruth Martin					2. Date of Death Month March	Day 28	Year 2007	3. Time of Death 09:35 P M		
	4a. Facility Name (If not institution, give street and number) Anne Arundel Medical Center					4b. City, Town, or Location of Death Annapolis			4c. County of Death Anne Arundel		
Funeral Director	5. Social Security Number 577-24-6871	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 84 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) 10/28/1922	9. Birthplace (State or Foreign Country) Pennsylvania				
To Be Completed by Funeral Director	10a. State Maryland					10b. County Anne Arundel			10c. City, Town or Location Davidsonville	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	10e. Street and Number 704 Petersburg Road					10f. Zip Code 21035			10g. Citizen of What Country? United States		
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12					16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker			16b. Kind of Business/Industry Home		
	17. Father's Name (First, Middle, Last) Van McKinstry McMains					18. Mother's Name (First, Middle, Maiden Surname) Lillian Calhoun					
	19a. Informant's Name/Relationship (Type. Print) Evelyn Bickford/Daughter					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 704 Petersburg Road, Davidsonville, Maryland 21035					
	20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) Lakemont Memorial Gardens					20b. Place of Disposition (Name of cemetery, crematory or other place) Lakemont Memorial Gardens			Date 04/02/2007	20c. Location - City or Town, State Davidsonville, Maryland	
	21. Signature of Funeral Service Licensee 					22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Road, Edgewater, MD 21037					
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Pneumonia					Approximate Interval Between Onset and Death days					
	a. Due to (or as a consequence of): Pneumonia b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):										
	23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown					23c. If yes, outcome pf pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year		
Medical Certification: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Septic COPD					23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown					
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide					28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred		
						28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Medical Parkway			28f. Location (Street and Number or Rural Route Number, City or Town, State) Annapolis, MD		
	29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					29c. License number D46052			29d. Date signed (Month, Day, Year) 3/29/07		
	30. Name and address of person who completed cause of death (Item 23a) (Type. Print) Spiral Beach, MD 2001 Medical Parkway Annapolis, MD										
State Registrar	31. Date filed (Month, Day, Year) APR 02 2007			32. Registrar's Signature 							

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural"; or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

17

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2007 12477

1- For
State
Registrar

Physician
/Medical
Examiner

Baltimore, Maryland 21215-0036
Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
any time.

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Physician /Medical Examiner		1. Decedent's Name (First, Middle, Last) Mae Alice Morgan				2. Date of Death Month Day Year March 27, 2007		3. Time of Death 1:45 P M				
Funeral Director		4a. Facility Name (If not institution, give street and number) Holy Cross Hospital				4b. City, Town, or Location of Death Silver Spring		4c. County of Death Montgomery				
		5. Social Security Number 201-22-6899	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) Yrs. 77	If Under 1 Year Months 0	If Under 24 Hrs. Days 0	Hours 0	Min. 0	8. Date of Birth (Month, Day, Year) Aug. 7, 1929	9. Birthplace (State or Foreign Country) North Carolina		
		Usual Residence of Decedent 10a. State D.C. 10b. County None				10c. City, Town or Location Washington				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
		10e. Street and Number 2131 O Street N.W.				10f. Zip Code 20037		10g. Citizen of What Country? U.S.A.				
		11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: 12			13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: Black			14. Race - American Indian, Black, White, etc. Specify:			
		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Domestic Worker			16b. Kind of Business/Industry Private				
		17. Father's Name (First, Middle, Last) John Morgan				18. Mother's Name (First, Middle, Maiden Surname) Addie Merritt						
		19a. Informant's Name/Relationship (Type, Print) Katherine Wiedman (Guardian)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1710 Rhode Island Ave. N.W. Washington, DC 20036						
		20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) Dennis Pittman				20b. Place of Disposition (Name of cemetery, crematory or other place) Harmony Mem. Park		Date 4/4/07	20c. Location - City or Town, State Landover, MD			
		21. Signature of Funeral Service Licensee Dennis Pittman				22. Name and Address of Facility Hall Brothers Funeral Home 621 Florida Ave., N.W. Washington, DC 20001						
		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sepsis Syndrome Due to (or as a consequence of):								Approximate Interval Between Onset and Death		
		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Pneumonia Due to (or as a consequence of):										
		c. Due to (or as a consequence of):										
		d. Due to (or as a consequence of):										
		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome pf pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown					23d. Date of delivery Month Day Year			
		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Advanced Cancer of Breast, Atrial Fibrillation								23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
		Malignant Right Pleural Effusion								24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
		Failure To Thrive								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		
		25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred					
				28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)					28f. Location (Street and Number or Rural Route Number, City or Town, State)			
		29a. Certifier (Check only one) Rajan ShyamSundar, M.D.		29b. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					29d. Date signed (Month, Day, Year) March 28, 2007			
		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rajan ShyamSundar, M.D.		31. Date filed (Month, Day, Year) APR 04 2007					32. Registrar's Signature Rajan ShyamSundar			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2007 12478

1 - For State Registrar		Decedent's Name (First, Middle, Last)						2. Date of Death Month Day Year	3. Time of Death	
Physician /Medical Examiner		Louis Edward Misback						Mar 28, 2007	2:30 a M	
Funeral Director		4a. Facility Name (If not institution, give street and number)			4b. City, Town, or Location of Death			4c. County of Death		
		4505 Amherst Road			College Park			Prince George's		
		5. Social Security Number	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 83 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	Hours	Min.	8. Date of Birth (Month, Day, Year) 07-30-1923	9. Birthplace (State or Foreign Country) Kentucky
		Usual Residence of Decedent						10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
		10a. State	10b. County	10c. City, Town or Location						
		Maryland	Prince George's	College Park						
		10e. Street and Number			10f. Zip Code			10g. Citizen of What Country?		
		4505 Amherst Road			20740			U.S.A.		
		11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: 1943-1946	13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White			
		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Intelligence Analyst			16b. Kind of Business/Industry Dept. of State			
		17. Father's Name (First, Middle, Last) Louis B. Misback			18. Mother's Name (First, Middle, Maiden Surname) Henrietta Kupper					
		19a. Informant's Name/Relationship (Type, Print) Peggy Misback - Wife		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4505 Amherst Road, College Park, Maryland 20740						
		20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Metropolitan Crematory			Date	20c. Location - City or Town, State Alexandria, Virginia		
		21. Signature of Funeral Service License <i>Peggy M. May</i>		22. Name and Address of Facility Gasch's Funeral Home, P.A. Hyattsville, MD 20781			4739 Baltimore Ave.			
		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Primary Cause (Final disease or condition resulting in death) Myocardial Infarction Due to (or as a consequence of):						Approximate Interval Between Onset and Death 2 Months		
		b. Coronary Artery Disease Due to (or as a consequence of):								
		c. _____ Due to (or as a consequence of):								
		d. _____ Due to (or as a consequence of):								
		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year			
		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Pancreatic Insufficiency; Recurrent Cholangitis; Diabetes Mellitus						23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
								24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		
		25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred		
		5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined								
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State)		
		29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
		29b. Signature and title of Certifier <i>William S. Hughes</i>						29c. License number 4093	29d. Date signed (Month, Day, Year) 3/28/07	
		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) William S. Hughes, MD 3301 New Mexico Avenue, NW, Washington, DC								
State Registrar		31. Date filed (Month, Day, Year) APR 04 2007		32. Registrar's Signature <i>W. S. Hughes</i>						

Baltimore, Maryland 21215-0036

Permit Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural" or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

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To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007

12479

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) ELIZA J. McCOMB							2. Date of Death Month 03 Day 27 Year 2007	3. Time of Death 5:30 P M
	4a. Facility Name (If not institution, give street and number) HOLY CROSS HOSPITAL				4b. City, Town, or Location of Death SILVER SPRING			4c. County of Death Montgomery	
Funeral Director	5. Social Security Number 245-42-5649	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 96 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) 04-27-1910	9. Birthplace (State or Foreign Country) Lancaster, S.C.		
To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State Maryland 10b. County Montgomery				10c. City, Town or Location Silver Spring			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	10e. Street and Number 2101 Fair Lane Road				10f. Zip Code 20904			10g. Citizen of What Country? U.S.A.	
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: Black	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 6th				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker			16b. Kind of Business/Industry Own Home	
	17. Father's Name (First, Middle, Last) Charley Brice				18. Mother's Name (First, Middle, Maiden Surname) Julia Brice				
	19a. Informant's Name/Relationship (Type, Print) Gladys Brown/granddaughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2111 Varnum St., N.E. Wash., DC 20018				
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) Harmony Mem.Pk.				20b. Place of Disposition (Name of cemetery, crematory or other place) Harmony Mem.Pk.			Date 04-07-2007	
	21. Signature of Funeral Service, Licensee ► Mary Hedgeman MC1374				22. Name and Address of Facility Cedar Hill FH 4111 PA Ave. Suitland, Md. 20746			20c. Location - City or Town, State Landover, Md.	
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death
	<p>a. Cardiopulmonary Arrest Due to (or as a consequence of):</p> <p>b. End stage pulmonary Hypertension Due to (or as a consequence of):</p> <p>c. _____ Due to (or as a consequence of):</p> <p>d. _____</p>								
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown				23c. If yes, outcome pf pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown <input type="checkbox"/> Other (specify) _____			23d. Date of delivery Month Day Year	
Medical Certification: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Pneumonia								23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred		
			28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)					28f. Location (Street and Number or Rural Route Number, City or Town, State)	
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
	29b. Signature and title of certifier ► Smitha Bhikkaj M.D.		29c. License number D0064100		29d. Date signed (Month, Day, Year) 03-29-2007				
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Smitha Bhikkaj 1500 Forest Glen Road Silver Spring, Md. 20910								
State Registrar	31. Date filed (Month, Day, Year) APR 04 2007		32. Registrar's Signature ► D. Speltz						

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 12680

1- For State Registrar

Physician /Medical Examiner		1. Decedent's Name (First, Middle, Last) Andrew M. Moody						2. Date of Death Month Month Day Year March 26, 2007	3. Time of Death 3:30 P. M							
		4a. Facility Name (If not institution, give street and number) Southern Maryland Hospital Center			4b. City, Town, or Location of Death Clinton			4c. County of Death Prince George's								
Funeral Director		5. Social Security Number 578-38-7500	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 79 Yrs.	If Under 1 Year Months Days Hours Min. If Under 24 Hrs.	8. Date of Birth (Month, Day, Year) October 10, 1927			9. Birthplace (State or Foreign Country) Virginia							
		Usual Residence of Decedent D.C.			10c. City, Town or Location Washington			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No								
To Be Completed by Funeral Director		10e. Street and Number 3509 N Street, S.E.			10f. Zip Code 20019			10g. Citizen of What Country? U.S.A.								
		11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: 1927		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: Black			14. Race - American Indian, Black, White, etc. Specify: Black								
		15. Decedent's Education (Specify only highest grade completed) 12th grade	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Engineer		16b. Kind of Business/Industry Marriott Hotel											
		17. Father's Name (First, Middle, Last) Clifton C. Moody, Sr.			18. Mother's Name (First, Middle, Maiden Surname) Fannie Green											
		19a. Informant's Name/Relationship (Type, Print) Mr. Clifton C. Moody (Brother)			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3509 N Street, S.E. Washington, D.C. 20019											
		20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) Quantico National Cemetery		20b. Place of Disposition (Name of cemetery, crematory or other place) Quantico National Cemetery		Date April 6, 2007	20c. Location - City or Town, State Triangle, Virginia									
		21. Signature of Funeral Service Licensee Jont C. Anderson		22. Name and Address of Facility Rollins Funeral Home, Inc.		23. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Acute Myocardial Infarction			Approximate Interval Between Onset and Death							
		Immediate Cause (Final disease or condition resulting in death)		a. Due to (or as a consequence of): Acute Myocardial Infarction												
		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		b. Due to (or as a consequence of):												
				c. Due to (or as a consequence of):												
				d. Due to (or as a consequence of):												
Physician /Medical Examiner		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) Unknown			23d. Date of delivery Month Day Year									
		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown					
											24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
		25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Determined <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide					28a. Date of Injury (Month, Day Year) March 26, 2007	28b. Time of Injury M M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No No	28d. Describe how injury occurred	
												28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
		29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.														
		29b. Signature and title of certifier Richard Patmen MD		29c. License number D0055120			29d. Date signed (Month, Day, Year) March 26 2007									
		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Richard Patmen MD 1328 Southern Avenue SE Suite 310 Washington DC 20032														
		31. Date filed (Month, Day, Year) APR 03 2007		32. Registrar's Signature D. Spiller												

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
 Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

State Registrar

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or if item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

1 - For State Registrar		State of Maryland / Department of Health and Mental Hygiene Certificate of Death						Reg. No. 2007 12481
Physician /Medical Examiner		1. Decedent's Name (First, Middle, Last) Delores Elizabeth Moody-Green				2. Date of Death Month March Day 24 Year 2007		3. Time of Death 8:00 A M
Funeral Director		4a. Facility Name (If not institution, give street and number) 3202 Curtis Drive #101			4b. City, Town, or Location of Death Temple Hills			4c. County of Death Prince George's
		5. Social Security Number 579-56-9101	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 70 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days Hours Min.	8. Date of Birth (Month, Day, Year) Sept. 26, 1936	9. Birthplace (State or Foreign Country) Nashville, TN
		Usual Residence of Decedent 10a. State Maryland			10b. County Prince George's			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
		10e. Street and Number 3202 Curtis Drive #101			10f. Zip Code 20748			10g. Citizen of What Country? United States
		11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: Black			14. Race - American Indian, Black, White, etc. Specify: Black	
		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Accounting Clerk	16b. Kind of Business/Industry Government				
		17. Father's Name (First, Middle, Last) Edward King	18. Mother's Name (First, Middle, Maiden Surname) Harold Mae Poole					
		19a. Informant's Name/Relationship (Type, Print) Edward King/Brother	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5211 Newton Street #303, Bladensburg, MD 20710					
		20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) Charles E. Young	20b. Place of Disposition (Name of cemetery, crematory or other place) Ft. Lincoln	Date 3/31/2007	20c. Location - City or Town, State Brentwood, MD			
		21. Signature of Funeral Service Licensee Charles E. Young	22. Name and Address of Facility Pope Funeral Homes, P.A. 5538 Marlboro Pike, Forestville, MD 20747					
		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sudden Death Due to (or as a consequence of): Cardiac Arrest Due to (or as a consequence of): Gastro Enteritis Due to (or as a consequence of): d.						Approximate Interval Between Onset and Death
		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown	23d. Date of delivery Month Day Year				
		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. History of hypertension, seizure disorder, lacunar infarcts						23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown
		25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred		
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)			
		29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.						
		29b. Signature and title of certifier Susan H. Houseman, MD	29c. License number DC 9603			29d. Date signed (Month, Day, Year) 3/27/2007		
		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Susan H. Houseman, MD 2100 Pennsylvania Avenue, NW, Washington, DC 20037						
		31. Date filed (Month, Day, Year) APR 03 2007	32. Registrar's Signature Barbara A. Parker					

State Registrar
CR 10

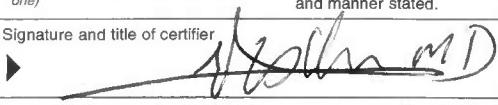
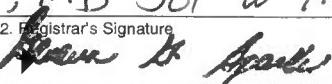
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 12482

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) CHARLES N. MOSSBURG, JR.					2. Date of Death Month April Day 3, Year 2007	3. Time of Death 9:20 P M	
	4a. Facility Name (If not institution, give street and number) 5821-B, Bells Lane			4b. City, Town, or Location of Death Frederick		4c. County of Death Frederick		
Funeral Director	5. Social Security Number 212-38-8786		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) Yrs. 67	If Under 1 Year Months	If Under 24 Hrs. Days Hours Min.	8. Date of Birth (Month, Day, Year) FEB. 15, 1940	9. Birthplace (State or Foreign Country) Maryland
	Usual Residence of Decedent 10a. State Maryland 10b. County Frederick 10c. City, Town or Location Frederick							10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
To Be Completed by Funeral Director	10e. Street and Number 5821-B, Bells Lane			10f. Zip Code 21704		10g. Citizen of What Country? United States		
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 9			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Tree Trimmer / Arborist			16b. Kind of Business/Industry County Government		
17. Father's Name (First, Middle, Last) Charles N. Mossburg, Sr.				18. Mother's Name (First, Middle, Maiden Surname) Helen L. Roberts				
19a. Informant's Name/Relationship (Type, Print) Patsy Mae Mossburg / Wife			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5821 B., Bells La./ Frederick, Maryland 21704					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Mount Olivet Cem.			Date 04/07/2007	20c. Location - City or Town, State Frederick, Maryland	
21. Signature of Funeral Service Licensee 			22. Name and Address of Facility Stauffer Funeral Home / 1621 Opossumtown Pike/ Frederick, MD 21702					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) metastatic lung cancer Approximate Interval Between Onset and Death 8 m								
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last a. Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):								
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			23c. If yes, outcome pf pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								
23e. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown								
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred		
28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)						
29a. Certifier <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier 				29c. License number D 48184			29d. Date signed (Month, Day, Year) 4/4/07	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Elhamy Eskander, MD 501 w 7th street Frederick, MD 21701								
31. Date filed (Month, Day, Year) APR 05 2007			32. Registrar's Signature 					

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2007 12483

1- For State Registrar		2. Date of Death Month Day Year APRIL 7 2007										3. Time of Death M	
Physician /Medical Examiner		1. Decedent's Name (First, Middle, Last) ALICE ROMAINE MOSER										4c. County of Death WASHINGTON	
Funeral Director		4a. Facility Name (If not institution, give street and number) 427 NORTH MAIN STREET			4b. City, Town, or Location of Death BOONSBORO			4c. County of Death WASHINGTON					
To Be Completed by Funeral Director		5. Social Security Number 214-09-4192		6. Sex 1 ♂ M 2 ♀ F	7. Age (In yrs. last birthday) 89 Yrs.	If Under 1 Year Months 89	If Under 24 Hrs. Days 0	Hours 0	Min. 0	8. Date of Birth (Month, Day, Year) SEPT. 16, 1917	9. Birthplace (State or Foreign Country) MARYLAND		
		Usual Residence of Decedent 10a. State MARYLAND 10b. County WASHINGTON 10c. City, Town or Location BOONSBORO										10d. Inside City Limits 1 ☑ Yes 2 □ No	
		10e. Street and Number 427 NORTH MAIN STREET				10f. Zip Code 21713				10g. Citizen of What Country? U.S.A.			
		11. Marital Status 1 □ Never Married 2 ☑ Married 3 ☑ Widowed 4 □ Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ☑ No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 □ Yes 2 ☑ No Specify:			14. Race - American Indian, Black, White, etc. WHITE				
		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) HOMEMAKER			16b. Kind of Business/Industry OWN HOME					
		17. Father's Name (First, Middle, Last) RUSSELL DAVID ANDERSON				18. Mother's Name (First, Middle, Maiden Surname) LOTTIE ALICE LONG							
		19a. Informant's Name/Relationship (Type, Print) KENNETH W. ANDERSON/BROTHER				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10910 GAYWOOD DRIVE, HAGERSTOWN, MARYLAND 21740							
		20a. Method of Disposition 1 ☑ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) BOONSBORO CEMETERY		Date 4/10/2007		20c. Location - City or Town, State BOONSBORO, MARYLAND					
		21. Signature of Funeral Service Licensee Paul M. Dean		22. Name and Address of Facility BAST FUNERAL HOME		23. Date of delivery Month Day Year 7606 Old National Pike Boonsboro, Maryland 21713							
		23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last										Approximate Interval Between Onset and Death	
		<p>a. Due to (or as a consequence of): <i>Huerte Myocardial Artery Disease I mmed</i></p> <p>b. Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. Due to (or as a consequence of):</p>											
		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown		23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 9 □ Unknown		23d. Date of delivery Month Day Year							
		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Hypertension. Unexplained wt loss</i>										23e. Did tobacco use contribute to the cause of death? 1 □ Yes 2 ☑ No 3 □ Probably 4 □ Unknown	
		25. Was case referred to medical examiner? 1 □ Yes 2 ☑ No		26. Place of Death (Check only one) Hospital: 1 □ Inpatient 2 □ ER/Outpatient 3 □ DOA Other: 4 □ Nursing Home 5 ☑ Residence 6 □ Other (Specify)		24a. Was an autopsy performed? 1 □ Yes 2 ☑ No					24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No		
		27. Manner of Death 1 ☑ Natural 2 □ Accident 3 □ Suicide 4 □ Homicide		28a. Date of Injury (Month, Day Year) M		28b. Time of Injury M		28c. Injury at Work? 1 □ Yes 2 □ No		28d. Describe how injury occurred			
		5 □ Pending investigation 6 □ Could not be determined		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)							
		29a. Certifier (Check only one) 1 ☑ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 □ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29c. License number DZ3815		29d. Date signed (Month, Day, Year) 4/9/07							
		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mary E Money 354 N. 11 St Hagerstown, MD 21740		31. Date filed (Month, Day, Year) APR 09 2007		32. Registrar's Signature Barbara G. Spotts							

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a show any injury or other traumatic event, the physician must initial the box below once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene
Certificate of Death

Reg. No. 2007 12484

1- For
State
Registrar

Physician
/Medical
Examiner

		1. Decedent's Name (First, Middle, Last)		John Mc Williams		2. Date of Death	Month April Day 2 Year 2007		3. Time of Death	1035 M				
		4a. Facility Name (If not institution, give street and number)		Coastal Hospice at the Lake		4b. City, Town, or Location of Death		Salisbury		4c. County of Death		Wicomico		
Funeral Director		5. Social Security Number		6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	9. Birthplace (State or Foreign Country)		10d. Inside City Limits			
		219-26-7164		1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	68 Yrs.	Months	Days	Hours	Min.	4/27/1938	1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		Maryland	
To Be Completed by Funeral Director		10a. State		10b. County		10c. City, Town or Location								
		Maryland		Wicomico		Salisbury								
		10e. Street and Number				10f. Zip Code		10g. Citizen of What Country?						
		1106 Nevins Place				21804		USA						
		11. Marital Status		12. Was Decedent Ever in U.S. Armed Forces?		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)		14. Race - American Indian, Black, White, etc.						
		1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: Army		1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		Specify: white						
		15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)		16b. Kind of Business/Industry								
		Elementary/Secondary (0-12) 12		College (1-4 or 5+) 2		Auditor		State						
		17. Father's Name (First, Middle, Last)		18. Mother's Name (First, Middle, Maiden Surname)										
		Joseph Patrick McWilliams		Bertha Seiford										
		19a. Informant's Name/Relationship (Type, Print)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)										
		Naomi L. McWilliams/wife		1106 Nevins Place, Salisbury, MD 21804										
		20a. Method of Disposition		20b. Place of Disposition (Name of cemetery, crematory or other place)		Date		20c. Location - City or Town, State						
		1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		Allen Cemetery		4/5/07		Allen, MD						
		21. Signature of Funeral Service Licensee		22. Name and Address of Facility										
		WR Williams CFSP		Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804										
		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.												
		Immediate Cause (Final disease or condition resulting in death)		a. Hepatoma Due to (or as a consequence of):										
		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		b. Cirrhosis Due to (or as a consequence of):										
				c. Due to (or as a consequence of):										
				d. Due to (or as a consequence of):										
		IF FEMALE:		23b. Was decedent pregnant in the past 12 months?		23c. If yes, outcome pf pregnancy		23d. Date of delivery						
		1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown		1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 4 <input type="checkbox"/> Pregnant at time of death 9 <input type="checkbox"/> Unknown		3 <input type="checkbox"/> Ectopic pregnancy 5 <input type="checkbox"/> Other (specify)		Month		Day		Year		
		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23e. Did tobacco use contribute to the cause of death?						
								1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown						
		25. Was case referred to medical examiner?		Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA		Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		26. Place of Death (Check only one)						
		1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No												
		27. Manner of Death		5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury		28c. Injury at Work?		28d. Describe how injury occurred		
		1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				M		1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No						
				28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State)				
		29a. Certifier (Check only one)		Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
		2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.												
		29b. Signature and title of certifier		29c. License number		29d. Date signed (Month, Day, Year)								
		David E. Connelly, MD		D26278		4-3-07								
		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)												
		David E. Connelly, MD Coastal Hospice PO Box 1733 Salisbury, MD 21802												
		31. Date filed (Month, Day, Year)		32. Registrar's Signature										
		APR 05 2007		Steve E. Connelly										

Baltimore, Maryland 21215-0036

Permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2007 12485

Reg. No.

1- For
State
Registrar

Physician
/Medical
Examiner

Funeral
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year			3. Time of Death
Harold Glenn Moyer Jr.		03 29 2007			06:00 M
4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of Death			4c. County of Death
Peninsula Regional Medical Center		Salisbury, Maryland			Wicomico
5. Social Security Number	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 79 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) July 10, 1927
213-22-4847					9. Birthplace (State or Foreign Country) Delaware
Usual Residence of Decedent		10c. City, Town or Location			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Maryland	Wicomico	Parsonsburg			
10e. Street and Number 7545 Lovy Lane		10f. Zip Code 21849			10g. Citizen of What Country? USA
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: Army		13. Was Decedent of Hispanic Origin? (Specify Yes or No) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White
Elementary/Secondary (0-12) 12	15. Decedent's Education (Specify only highest grade completed) College (1-4 or 5+) --		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Master Electrician		16b. Kind of Business/Industry Owner/Operator
17. Father's Name (First, Middle, Last) Harold Glen Moyer Sr.		18. Mother's Name (First, Middle, Maiden Surname) Anna Brown			
19a. Informant's Name/Relationship (Type, Print) Grace Moyer/Wife		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7545 Lovy Lane Parsonsburg, Maryland 21849			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Odd Fellows Cemetery		Date 3/31/2007	20c. Location - City or Town, State Seaford, Delaware
21. Signature of Funeral Service License ► <i>Kath R. Disney CFSP</i>		22. Name and Address of Facility Holloway Funeral Home P.A. 501 Snow Hill Rd. Salisbury, Maryland 21804			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) { a. SEPSIS Due to (or as a consequence of): b. PNEUMONIA Due to (or as a consequence of): c. Due to (or as a consequence of): d. _____ Approximate Interval Between Onset and Death 0 days 0 days					
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) _____			23d. Date of delivery Month Day Year
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. PARKINSON'S DISEASE					
23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred
5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier ► <i>Svetlana Gutierrez MD</i>		29c. License number D0062916			29d. Date signed (Month, Day, Year) MARCH 30, 2007
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Svetlana Gutierrez 1415 South Division Suite B Salisbury MD 21804					
31. Date filed (Month, Day, Year) APR 03 2007		32. Registrar's Signature <i>Svetlana Gutierrez</i>			

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2007 12486

Reg. No.

1- For
State
Registrar

**Physician
/Medical
Examiner**

**Funeral
Director**

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23c or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

1. Decedent's Name (First, Middle, Last)

Marion Norris

2. Date of Death
Month Day Year
April 3, 2007

3. Time of Death
7:00 A M

4a. Facility Name (If not institution, give street and number)

Rockville Nursing Home

4b. City, Town, or Location of Death
Rockville

4c. County of Death
Montgomery

5. Social Security Number

577-34-3804

6. Sex

M F

7. Age (In yrs. last birthday)

78

Yrs.

If Under 1 Year
Months Days Hours Min.

8. Date of Birth
(Month, Day, Year)

April 8, 1928

9. Birthplace (State or Foreign Country)

New York

Usual Residence of Decedent

10a. State
Maryland

10b. County
Frederick

10c. City, Town or Location
Frederick

10d. Inside City Limits
 Yes No

10e. Street and Number

2500 Waterside Drive

10f. Zip Code
21701

10g. Citizen of What Country?
USA

11. Marital Status

Never Married Married
 Widowed Divorced

12. Was Decedent Ever in U.S. Armed Forces?

Yes No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

Yes No
Specify:

14. Race - American Indian, Black, White, etc.
Specify: white

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

1

16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

Sales representative

16b. Kind of Business/Industry

Structural Systems, Inc.

17. Father's Name (First, Middle, Last)

Carl Albert Lundberg

18. Mother's Name (First, Middle, Maiden Surname)

Marion MacDonald

19a. Informant's Name/Relationship (Type, Print)

Kathy Brown - daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

12601 Fingerboard Road, Monrovia, Maryland 21770

20a. Method of Disposition

Burial Cremation Removal from State
 Donation Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Ft Lincoln Cemetery

Date

4-7-2007

20c. Location - City or Town, State

Brentwood, Maryland

21. Signature of Funeral Service Licensee



22. Name and Address of Facility

Stauffer Funeral Home

1621 Opossumtown Pike, Frederick, Maryland 21702

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

gangrene feet

Approximate Interval Between Onset and Death
2 weeks

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

a. Due to (or as a consequence of):

diabetes

years

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

Yes No

23c. If yes, outcome of pregnancy

Live birth Fetal death Ectopic pregnancy

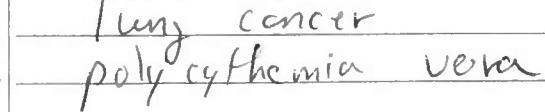
Pregnant at time of death Other (Specify)

Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.



23e. Did tobacco use contribute to the cause of death?

Yes No Probably Unknown

25. Was case referred to medical examiner?

Yes No

26. Place of Death (Check only one)

Hospital: Inpatient ER/Outpatient DODA

Other:

Nursing Home Residence Other (Specify)

27. Manner of Death

Natural

Accident

Suicide

Homicide

Pending investigation

Could not be determined

28a. Date of Injury (Month, Day, Year)

M

28b. Time of Injury

M

28c. Injury at Work?

Yes No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier



29c. License number

D19294

29d. Date signed (Month, Day, Year)

April 3, 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



31. Date filed (Month, Day, Year)

APR 05 2007

32. Registrar's Signature



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

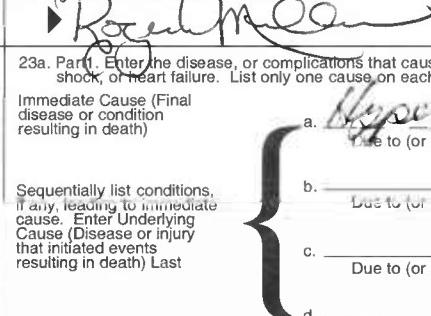
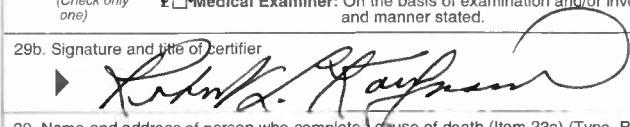
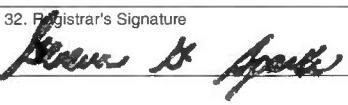
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007

12487

1- For State Registrar

Physician /Medical Examiner		1. Decedent's Name (First, Middle, Last) PEARL L NICHOLS 2. Date of Death Month Day Year APRIL 2, 2007 3. Time of Death 10:35AM					
Funeral Director		4a. Facility Name (If not institution, give street and number) FREDERICK MEMORIAL HOSPITAL 4b. City, Town, or Location of Death FREDERICK 4c. County of Death FREDERICK					
To Be Completed by Funeral Director		5. Social Security Number 209-28-9516 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F 7. Age (In yrs. last birthday) 68 Yrs. If Under 1 Year Months Days Hours Min. 8. Date of Birth Month Day Year 6/23/1938 9. Birthplace (State or Foreign Country) Pennsylvania					
To Be Completed by Physician/Medical Examiner		10a. State Maryland 10b. County Frederick 10c. City, Town or Location Frederick 10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No					
To Be Completed by Physician/Medical Examiner		10e. Street and Number 999 Heatheridge Drive Unit G 10f. Zip Code 21702 10g. Citizen of What Country? USA					
To Be Completed by Physician/Medical Examiner		11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: 14. Race - American Indian, Black, White, etc. Specify: White					
To Be Completed by Physician/Medical Examiner		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Branch Chief Secretary 16b. Kind of Business/Industry US Government					
To Be Completed by Physician/Medical Examiner		17. Father's Name (First, Middle, Last) Charles Abbott 18. Mother's Name (First, Middle, Maiden Surname) Ruth Mellott					
To Be Completed by Physician/Medical Examiner		19a. Informant's Name/Relationship (Type, Print) Ricky Nichols/Son 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 999 Heatheridge Dr. Unit G, Frederick, MD 21702					
To Be Completed by Physician/Medical Examiner		20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) Stauffer Crematory 20c. Location - City or Town, State Frederick, MD 21702 Date 4/6/2007					
To Be Completed by Physician/Medical Examiner		21. Signature of Funeral Service Licensee  22. Name and Address of Facility Stauffer FuneralHome, PA 1621 Opossumtown Pike, Frederick, MD 21702					
To Be Completed by Physician/Medical Examiner		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Hypertensive Cardiovascular Disease Approximate Interval Between Onset and Death 10 yrs. a. Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.					
To Be Completed by Physician/Medical Examiner		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown 23c. If yes, outcome pf pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) _____ 9 <input type="checkbox"/> Unknown 23d. Date of delivery Month Day Year					
To Be Completed by Physician/Medical Examiner		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Chronic Renal Failure 23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown					
To Be Completed by Physician/Medical Examiner		24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No					
To Be Completed by Physician/Medical Examiner		25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
To Be Completed by Physician/Medical Examiner		26. Place of Death (Check only one) 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Injury at Work? 4 <input type="checkbox"/> Homicide M 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred					
To Be Completed by Physician/Medical Examiner		28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)					
To Be Completed by Physician/Medical Examiner		29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier  29c. License number D-13971 29d. Date signed (Month, Day, Year) 4/4/07					
To Be Completed by Physician/Medical Examiner		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Robert Kaufmann 300 W. Ninth Street Frederick, MD 21701					
State Registrar		31. Date filed (Month, Day, Year) APR 05 2007 32. Registrar's Signature 					

Baltimore, Maryland 21215-0036

permit Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
 Important: If item 27 is marked other than "natural", or items 23a or 28a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division or Vital Records, P.O. Box 68760,

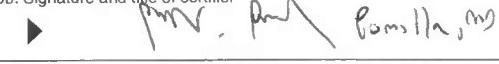
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene
Certificate of Death

2007 12488
Reg. No.

1- For State Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Carole Ann Poole							2. Date of Death Month March Day 23 Year 2007	3. Time of Death 10:10 PM			
	4a. Facility Name (If not institution, give street and number) Calvert Memorial Hospital			4b. City, Town, or Location of Death Prince Frederick			4c. County of Death Calvert					
Funeral Director	5. Social Security Number 212-42-7173	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 63 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) 10/10/1943	9. Birthplace (State or Foreign Country) Washington, D.C.					
To Be Completed by Funeral Director	10a. State Maryland		10b. County Anne Arundel	10c. City, Town or Location Edgewater				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				
	10e. Street and Number 1726 Chesapeake Drive			10f. Zip Code 21037			10g. Citizen of What Country? United States					
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White				
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Office Worker			16b. Kind of Business/Industry BG&E					
	17. Father's Name (First, Middle, Last) Robert F. Gebhardt				18. Mother's Name (First, Middle, Maiden Surname) Margaret A. Stazel							
	19a. Informant's Name/Relationship (Type, Print) Robert Scott Poole-Son				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 982 Eagle Pt., Lusby, Maryland 20657							
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Lakemont Memorial Gardens			Date 03/29/2007	20c. Location - City or Town, State Davidsonville, Maryland					
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd., Edgewater, MD 21037							
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. squamous cell cancer of head and neck Due to (or as a consequence of): b. Diabetes mellitus Due to (or as a consequence of): c. ventricular tachycardia Due to (or as a consequence of): d. hypothyroidism Due to (or as a consequence of):								Approximate Interval Between Onset and Death 3 years			
Medical Certification: To Be Completed by Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown				23c. If yes, outcome pf pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year				
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. diabetes mellitus ventricular tachycardia hypothyroidism								23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown			
									24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA			Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		26. Place of Death Check only one				
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred					
			28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)							
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.											
	29b. Signature and title of certifier 		29c. License number 046314 m0			29d. Date signed (Month, Day, Year) 3/24/07						
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Paul V. Pomilla, 110 Hospital Road, Suite 310, Prince Frederick, MD 20678											
State Registrar	31. Date filed (Month, Day, Year) MAR 26 2007		32. Registrar's Signature 									

Baltimore, Maryland 21215-0036

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2007 12489

Certificate of Death

Reg. No.

1- For
State
Register

Physician / Medical Examiner	1. Decedent's Name (First, Middle, Last) Irene Parus						2. Date of Death Month Day Year April 1, 2007	3. Time of Death 1:00 AM		
	4a. Facility Name (If not institution, give street and number) 4113 Haywood Avenue			4b. City, Town, or Location of Death Baltimore			4c. County of Death			
Funeral Director	5. Social Security Number 145-30-9472	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 82 Yrs.	If Under 1 Year Months 0	If Under 24 Hrs. Hours 0	Min. 0	8. Date of Birth (Month, Day, Year) Mar. 11, 1925	9. Birthplace (State or Foreign Country) Poland		
	Usual Residence of Decedent 10a. State Maryland 10b. County Baltimore 10c. City, Town or Location Baltimore 10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No									
To Be Completed by Funeral Director	10e. Street and Number 4113 Haywood Avenue			10f. Zip Code 21215			10g. Citizen of What Country? USA			
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 6			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Homemaker			16b. Kind of Business/Industry Own Home			
	17. Father's Name (First, Middle, Last) Henry Kubacki				18. Mother's Name (First, Middle, Maiden Surname) Christine Parus - Daughter Unknown					
	19a. Informant's Name/Relationship (Type, Print) Christine Parus - Daughter						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3909 Kennedy St., Hyattsville, MD 20781			
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Metropolitan Crematory			Date 4/2/2007	20c. Location - City or Town, State Alexandria, Virginia		
	21. Signature of Funeral Service Licensee John J. Parus MO1373						22. Name and Address of Facility Gasch's Funeral Home, P.A. Hyattsville, MD 20781	4739 Baltimore Ave.		
Physician / Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Alzheimer's Disease								Approximate Interval Between Onset and Death	
	b. Due to (or as a consequence of): CerebroVascular Insufficiency									
	c. Due to (or as a consequence of): Essential Hypertension									
	d. Due to (or as a consequence of):									
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 9 <input type="checkbox"/> Unknown					23d. Date of delivery Month Day Year		
Medical Certification: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Chronic Condition								23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown	
									24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
									24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
	27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year) 28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred			
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) At home				28f. Location (Street and Number or Rural Route Number, City or Town, State) Pikeville, Maryland			
	29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29c. License number 014753							
	29b. Signature and title of certifier Ronald Kevern Parus		29d. Date signed (Month, Day, Year) 4/2/07							
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4000 Old Court Road Suite 300, P. Keswick, Maryland									
State Registrar	31. Date filed (Month, Day, Year) APR 04 2007		32. Registrar's Signature Ronald Kevern Parus							

Baltimore, Maryland 21215-0036

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importantly: If Item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene
2007 12490
Certificate of Death

1- For
State
Registrar

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Lawrence Elvin Palmer	Mar. 30, 2007	7:20 A M

Funeral
Director

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death			
Doctors Community Hospital	Lanham	Prince George's			
5. Social Security Number	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 82 Yrs.	If Under 1 Year Months Days Hours Min.	8. Date of Birth (Month, Day, Year) Oct 22, 1924	9. Birthplace (State or Foreign Country) Maryland

Baltimore, Maryland 21215-0036
Permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 23a-1 show
any injury or other traumatic event, the Medical Examiner must be notified at
once.

To Be Completed by Funeral Director

Usual Residence of Decedent		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
10a. State	10b. County	10c. City, Town or Location Greenbelt			
Maryland	Prince George's				
10e. Street and Number 7 Fayette Place		10f. Zip Code 20770		10g. Citizen of What Country? USA	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: 1943-1945	13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	14. Race - American Indian, Black, White, etc. Specify: White		

15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 6	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Plumber	16b. Kind of Business/Industry W.G. Cornell
17. Father's Name (First, Middle, Last) Joseph Palmer	18. Mother's Name (First, Middle, Maiden Surname) Olive Padgett	
19a. Informant's Name/Relationship (Type, Print) Shirley Anne Palmer - Wife	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7 Fayette Place, Greenbelt, MD 20770	
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)	20b. Place of Disposition (Name of cemetery, crematory or other place) Cedar Hill Cemetery	20c. Date 4/3/2007
21. Signature of Funeral Service License <i>Michelle C. Palmer</i>	22. Name and Address of Facility Gasch's Funeral Home, P.A.	20c. Location - City or Town, State Suitland, Maryland
		4739 Baltimore Ave. Hyattsville, MD 20781

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)	Approximate Interval Between Onset and Death	
a. Aspiration pneumonia Due to (or as a consequence of):		
b. Urosepsis Due to (or as a consequence of):		
c. Emphysema Due to (or as a consequence of):		
d. Hypotension		
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____	23d. Date of delivery Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Alzheimers	23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.	29c. License number MD 34722	29d. Date signed (Month, Day, Year) 3-30-2007
29b. Signature and title of certifier <i>Vicken Poochikian</i>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Vicken Poochikian, MD 5632 Annapolis Road, Ste 3, Bladensburg, MD 20710		
31. Date filed (Month, Day, Year) APR 04 2007	32. Registrar's Signature <i>Susan D. Parker</i>	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2007 12491

Reg. No.

1- For
State
RegistrarPhysician
/Medical
ExaminerFuneral
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

Permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or
any injury or other traumatic event, the Medical Examiner must be notified at
once.

Division of Vital Records, P.O. Box 68760,

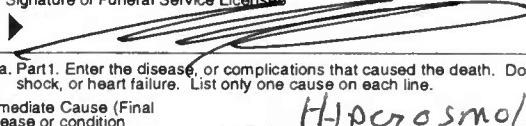
To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit
envelope.

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

DHMH 17 Rev 1/2001

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month Day Year				3. Time of Death		
Jennifer Edna Person			April 01, 2007				9:51 AM		
4a. Facility Name (If not institution, give street and number) DORCHESTER GENERAL HOSPITAL CAMBRIDGE			4b. City, Town, or Location of Death CAMBRIDGE				4c. County of Death DORCHESTER		
5. Social Security Number 579-86-4446		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 52 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) 09-04-1954	9. Birthplace (State or Foreign Country) New Jersey		
Usual Residence of Decedent 10a. State MD 10b. County Dorchester 10c. City, Town or Location Cambridge 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No									
10e. Street and Number 638 Washington St.			10f. Zip Code 21613			10g. Citizen of What Country? USA			
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) None		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Money Inspector		16b. Kind of Business/Industry US Treasury					
17. Father's Name (First, Middle, Last) Unknown			18. Mother's Name (First, Middle, Maiden Surname) Unknown						
19a. Informant's Name/Relationship (Type, Print) Joe Banks / Friend			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 638 Washinton St. Cambridge, MD 21613						
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Bethel Cemetery			Date 04/06/2007	20c. Location - City or Town, State Cambridge, MD		
21. Signature of Funeral Service Licensee 			22. Name and Address of Facility Bennie Smith Funeral Home 426 E. Dover St. Easton, MD 21601						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Hypoxsmolite State with shock								Approximate Interval Between Onset and Death ,	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last { a. Adult onset Diphile Due to (or as a consequence of): b. Refractory Metabolic Acidosis Due to (or as a consequence of): c. Refractory Metabolic Acidosis Due to (or as a consequence of): d. ,									
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____						23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown	
								24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)	
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)								28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								29d. Date signed (Month, Day, Year) April 2, 2007	
29b. Signature and title of certifier 				29c. License number 026388					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Michael J Fullmer MD 302 Collins Harlock Md 21643								31. Date filed (Month, Day, Year) APR 05 2007	
32. Registrar's Signature 									

ORIGINAL

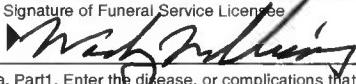
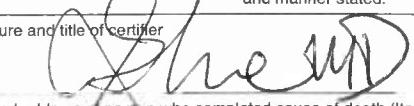
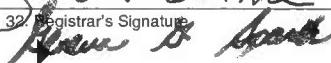
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007

12192

1- For State Registrar		Certificate of Death															
Physician /Medical Examiner		1. Decedent's Name (First, Middle, Last) James Austin Phillips				2. Date of Death Month April Day 4 Year 2007		3. Time of Death 3:59 a M									
Funeral Director		4a. Facility Name (If not institution, give street and number) 14991 Truman Manor Lane				4b. City, Town, or Location of Death Hughesville		4c. County of Death Charles									
To Be Completed by Funeral Director		5. Social Security Number 579-09-0324		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 86 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) June 27, 1920	9. Birthplace (State or Foreign Country) Washington D.C.								
		Usual Residence of Decedent 10a. State Maryland 10b. County Charles 10c. City, Town or Location Hughesville 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No															
		10e. Street and Number 14991 Truman Manor Lane				10f. Zip Code 20637		10g. Citizen of What Country? U.S.A.									
		11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White									
		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Carpenter		16b. Kind of Business/Industry Self Employed											
		17. Father's Name (First, Middle, Last) Clarence Edward Phillips				18. Mother's Name (First, Middle, Maiden Surname) Helen Young											
		19a. Informant's Name/Relationship (Type, Print) Richard J. Phillips Son		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 36713 Joan Dr., Mechanicsville, Md. 20659		20c. Location - City or Town, State Cheltenham, Maryland											
		20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Maryland Veterans Cemetery		20c. Location - City or Town, State Cheltenham, Maryland											
		21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Williams Funeral Home, P.A. 4270 Hawthorne Road, Indian Head, Md. 20640											
		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last															
		<table border="1"> <tr> <td>a. Due to (or as a consequence of): <i>Congestive Heart Failure</i></td> <td>Approximate Interval Between Onset and Death <i>>10 yrs</i></td> </tr> <tr> <td>b. Due to (or as a consequence of): <i>Atrial Fibrillation</i></td> <td><i>>10 yrs</i></td> </tr> <tr> <td>c. Due to (or as a consequence of): <i>Hypertension</i></td> <td><i>>10 yrs</i></td> </tr> <tr> <td>d.</td> <td></td> </tr> </table>								a. Due to (or as a consequence of): <i>Congestive Heart Failure</i>	Approximate Interval Between Onset and Death <i>>10 yrs</i>	b. Due to (or as a consequence of): <i>Atrial Fibrillation</i>	<i>>10 yrs</i>	c. Due to (or as a consequence of): <i>Hypertension</i>	<i>>10 yrs</i>	d.	
a. Due to (or as a consequence of): <i>Congestive Heart Failure</i>	Approximate Interval Between Onset and Death <i>>10 yrs</i>																
b. Due to (or as a consequence of): <i>Atrial Fibrillation</i>	<i>>10 yrs</i>																
c. Due to (or as a consequence of): <i>Hypertension</i>	<i>>10 yrs</i>																
d.																	
		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome pf pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown <input type="checkbox"/> Other (specify) _____		23d. Date of delivery Month Day Year											
		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.															
		23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown															
		<table border="1"> <tr> <td>24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</td> <td>24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</td> </tr> </table>								24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No																
		25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No															
		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) _____															
		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide															
		28a. Date of Injury (Month, Day, Year) 28b. Time of Injury M 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 28c. Injury at Work? 28d. Describe how injury occurred															
		28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)															
		28f. Location (Street and Number or Rural Route Number, City or Town, State)															
		29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.															
		29b. Signature and title of certifier 															
		29c. License number D0055724															
		29d. Date signed (Month, Day, Year) 4/4/07															
		30. Name and address of persons in who completed cause of death (Item 23a) (Type, Print) Jen Estine 29431 Charlotte Hall Rd Charlotte Hall															
		31. Date filed (Month, Day, Year) APR 05 2007															
		32. Registrar's Signature  20622															

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State Registrar

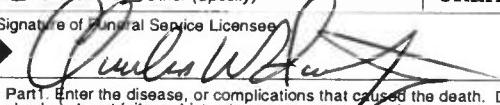
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 12493

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) WALTER MARTIN PILACHOWSKI JR.							2. Date of Death Month Day Year APRIL 3 2007	3. Time of Death 1846 M	
	4a. Facility Name (If not institution, give street and number) ATLANTIC GENERAL HOSPITAL				4b. City, Town, or Location of Death BERLIN			4c. County of Death WORCESTER		
Funeral Director	5. Social Security Number 215-58-4337	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 58 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	Hours	Min.	8. Date of Birth (Month, Day, Year) FEB. 16, 1949	9. Birthplace (State or Foreign Country) MARYLAND	
	Usual Residence of Decedent 10a. State DELAWARE 10b. County SUSSEX 10c. City, Town or Location SELBYVILLE								10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
To Be Completed by Funeral Director	10e. Street and Number 38232 MURPHY CIRCLE EAST				10f. Zip Code 19975			10g. Citizen of What Country? USA		
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: VIETNAM			13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: WHITE		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) EQUIPMENT OPERATOR			16b. Kind of Business/Industry LONGSHOREMAN		
	17. Father's Name (First, Middle, Last) WALTER M. PILACHOWSKI SR.				18. Mother's Name (First, Middle, Maiden Surname) DOROTHY BECKMAN					
	19a. Informant's Name/Relationship (Type, Print) MARY LINDA PILACHOWSKI/WIFE				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 38232 MURPHY CIRCLE EAST, SELBYVILLE, DE. 19975					
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) CREMATORIAL OF DELMARVA			Date 4/4/07	20c. Location - City or Town, State DELMAR, DELAWARE	
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility HASTINGS FUNERAL HOME, SELBYVILLE, DE. 19975					
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) ACUTE MYOCARDIAL INFARCTION								Approximate Interval Between Onset and Death FEW MINUTES	
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last									
	<p>a. Due to (or as a consequence of): ACUTE MYOCARDIAL INFARCTION</p> <p>b. Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. _____</p>									
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown				23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year		
Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit document.									24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No
Medical Certification: To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No								26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)	
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide				28a. Date of Injury (Month, Day Year)		28b. Time of Injury	28c. Injury at Work? M <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)								28f. Location (Street and Number or Rural Route Number, City or Town, State)	
	29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								29c. License number D06241	
	29b. Signature and title of certifier 								29d. Date signed (Month, Day, Year) 3-4-07	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DOROTHY C. HOZINORTH, N.D. 205 Snow St. Snow Hill, MD. 21863									
	31. Date filed (Month, Day, Year) APR 05 2007				32. Registrar's Signature 					

ORIGINAL

State
Registrar

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28e-1 show any injury or other traumatic event, the Medical Examiner must be notified.

Walter Pilachowski D.O.B. 2/16/1949
215-58-4337 D.O.D. 4/3/2007 1846
Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit document.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2007 12494

Rag. No.

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Mildred Bowdoin Parks							2. Date of Death Month Month Day Year March 31, 2007	3. Time of Death p 10:48	
	4a. Facility Name (If not institution, give street and number) 5429 E. Nithsdale Drive			4b. City, Town, or Location of Death Salisbury			4c. County of Death Wicomico			
Funeral Director	5. Social Security Number 266-03-4708	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 90 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Hours	8. Date of Birth (Month, Day, Year) 2/4/1917	9. Birthplace (State or Foreign Country) Virginia			
To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State Maryland 10b. County Wicomico 10c. City, Town or Location Salisbury									10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No X
	10e. Street and Number 5429 E. Nithsdale Drive			10f. Zip Code 21801			10g. Citizen of What Country? USA			
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: white			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 2	Housewife			16b. Kind of Business/Industry Domestic			
	17. Father's Name (First, Middle, Last) Edward Charles Lewis				18. Mother's Name (First, Middle, Maiden Surname) Alma Elder					
	19a. Informant's Name/Relationship (Type, Print) William B. Parks/husband				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5429 E. Nithsdale Dr., Salisbury, MD 21801					
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Wicomico Memorial Park			Date 4/4/07	20c. Location - City or Town, State Salisbury, MD			
	21. Signature of Funeral Service Licensee WR Ballings CFSP		22. Name and Address of Facility Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804							
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last									Approximate Interval Between Onset and Death
	<p>a. <i>Anterior cervical condro-vertebral fusion</i> Due to (or as a consequence of):</p> <p>b. _____ Due to (or as a consequence of):</p> <p>c. _____ Due to (or as a consequence of):</p> <p>d. _____</p>									
Physician /Medical Examiner	If FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Unknown					23d. Date of delivery Month Day Year		
Medical Certification: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA			Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		26. Place of Death (Check only one)		
	27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred			
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)					28f. Location (Street and Number or Rural Route Number, City or Town, State)		
	29b. Signature and title of certifier J A Cockey, MD						29c. License number 00024-674		29d. Date signed (Month, Day, Year) 4/3/07	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) J A Cockey, MD 1546 S Division St, Salisbury, MD 21804									
	31. Date filed (Month, Day, Year) APR 05 2007		32. Registrar's Signature Debra L. Jones							

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Ballings

Within 24 hours after death.

Important: If item 27 is marked other than "natural", or items 23a or 28a-e show any injury or other traumatic event, the Medical Examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene
Amend #2 Per Phy G867 5/10/07 JH Certificate of Death

Reg. No. 2007 12695

For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Patricia Ann Pusey							2. Date of Death Month Day 2007 Year March 30, 1927	3. Time of Death M a 7:20
	4a. Facility Name (If not institution, give street and number) 4058 Allen Road							4b. City, Town, or Location of Death Eden	4c. County of Death Wicomico
Funeral Director	5. Social Security Number 217-30-9467	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 72 Yrs.	II Under 1 Year Months Days Hours Min.	II Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) 1/11/1935	9. Birthplace (State or Foreign Country) Maryland		
Usual Residence of Decedent 10a. State Maryland 10b. County Wicomico 10c. City, Town or Location Eden 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No									
10e. Street and Number 4058 Allen Road				10f. Zip Code 21822			10g. Citizen of What Country? USA		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: 1945-1946			13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: White			14. Race - American Indian, Black, White, etc. Specify: white	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Seamstress			16b. Kind of Business/Industry Shirt Manufacturing				
17. Father's Name (First, Middle, Last) Stingle Henry Taylor					18. Mother's Name (First, Middle, Maiden Surname) Maggie Myrtle Hopkins				
19a. Informant's Name/Relationship (Type, Print) William L. Pusey Jr/son					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) CFSP					20b. Place of Disposition (Name of cemetery, crematory or other place) St. Johns U.M. Church Cemetery	Date 4/4/07	20c. Location - City or Town, State Fruitland, MD		
21. Signature of Funeral Service Licensee David J. Thompson					Name and address of Facility Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Cancer of bile duct Approximate Interval Between Onset and Death									
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last {									
23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown									
23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Unknown									
23d. Date of delivery Month Day Year									
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Liver failure									
23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown									
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No									
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No									
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No									
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)									
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide									
28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? M <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 28d. Describe how injury occurred									
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)									
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
29b. Signature and title of certifier J A Cockey, M									
29c. License number 00025674									
29d. Date signed (Month, Day, Year) 4/2/07									
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) J A Cockey, 1346 S. Division St., Salisbury, MD 21804									
31. Date filed (Month, Day, Year) APR 03 2007									
32. Registrar's Signature Patricia Ann Pusey									

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a show any injury or other traumatic event, the Medical Examiner must be notified at once.

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2007 1249

1- For State
Registrar**Physician/
Medical Examiner****Funeral
Director****To Be Completed by Funeral Director****Baltimore, MD 21215-0036**

permit Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

1. Decedent's Name (First, Middle, Last) James Robert Ritchey				2. Date of Death Month April Day 10 , Year 2007			3. Time of Death 0610 hrs	
4a. Facility Name (if not institution, give street and number) 11 High View Road				4b. City, Town, or Location of Death Conowingo			4c. County of Death Cecil	
5. Social Security Number 182-58-6622	6. Sex 1 [X] M 2 [] F	7. Age (In yrs. last birthday) 37 Yrs.	If Under 1 Year Months 0	If Under 24 Hrs. Days 0	Hours 0	Min. 0	8. Date of Birth (MM/DD/YYYY) Sept 15, 1969	9. Birthplace (State or Foreign Country) PA
Usual Residence of Decedent 10a. State Maryland 10b. County Cecil 10c. City, Town or Location Conowingo								
10e. Street and Number 11 Highview Road				10f. Zip Code 21918			10g. Citizen of What Country? USA	
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married	12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No specify: White				14. Race - American Indian, Black, White, etc.		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 2		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Registered Nurse				16b. Kind of Business/Industry Healthcare		
17. Father's Name (First, Middle, Last) Ronald Ritchey				18. Mother's Name (First, Middle, Maiden Surname) Janice Blohm				
19a. Informant's Name/Relationship (Type, Print) Robin Ritchey/Wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11 Highview Road, Conowingo, MD 21918				
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other Specify: [Signature]				20b. Place of Disposition (Name of cemetery, crematory or other place) Jefferson Memorial Park			Date 4-17-07	20c. Location - City or Town, State Pittsburgh, PA
21. Signature of Funeral Service Licensee [Signature]				22. Name and Address of Facility R. T. Foard Funeral Home, P.A. 111 S. Queen Street, Rising Sun, MD 21911				

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		a. Morphine and prooxetine intoxication Due to (or as a consequence of):		Approximate Interval Between Onset and Death	
b. Due to (or as a consequence of):					
c. Due to (or as a consequence of):					
d. Due to (or as a consequence of):					
<input checked="" type="checkbox"/> UNPENDED <input type="checkbox"/> AMENDED #23a,27,28a-f, perME, g866, 4/25/07 TT					
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) 9 <input type="checkbox"/> Unknown		23d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					
23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown					
24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No			
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other: Scene			
27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input checked="" type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year) Fnd 4/10/2007		28b. Time of Injury Fnd 5:54 am	
		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28d. Describe how injury occurred unknown	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) found in residence		28f. Location (Street and Number or Rural Route Number, City or Town, State) 11 Highview Rd. Conowingo, MD	
29a. Certifier 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check only one) 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier Carol Allan		29c. License number O.C.M.E.			
29d. Date signed (Month, Day, Year) April 10, 2007					
30. Name and address of person who completed cause of death (Item 23a) Carol Allan, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201					
31. Date filed (Month, Day, Year) APR 13 2007		32. Registrar's Signature [Signature]			

ORIGINAL

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit

Medical Certification: To Be Completed by Physician/Medical Examiner**State
Registrar**

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2007 12497

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) GERALDINE MARGARET RICE					2. Date of Death Month Day Year April 10 2007	3. Time of Death 5:40 PM		
	4a. Facility Name (If not institution, give street and number) WASHINGTON COUNTY HOSPITAL			4b. City, Town, or Location of Death HAGERSTOWN		4c. County of Death WASHINGTON			
Funeral Director	5. Social Security Number 234-01-6929	6. Sex 1 □ M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 90 Yrs.	If Under 1 Year Months Days Hours Min. 0 0 0 0	If Under 24 Hrs. Hours Min. 0 0	8. Date of Birth (Month, Day, Year) JULY 11, 1916	9. Birthplace (State or Foreign Country) WEST VIRGINIA		
To Be Completed by Funeral Director	10a. State WV			10b. County BERKELEY	10c. City, Town or Location MARTINSBURG				
	10e. Street and Number 1000 WEST VIRGINIA AVENUE			10f. Zip Code 25401		10g. Citizen of What Country? USA			
	11. Marital Status 1 □ Never Married 2 □ Married 3 <input checked="" type="checkbox"/> Widowed 4 □ Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 □ Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 3			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) HOMEMAKER			16b. Kind of Business/Industry OWN HOME		
	17. Father's Name (First, Middle, Last) FLOYD HERMAN FOLTZ				18. Mother's Name (First, Middle, Maiden Surname) DELLA DAYTON				
	19a. Informant's Name/Relationship (Type, Print) HARRY C. VanMETRE/SON			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1000 WEST VIRGINIA AVENUE, MARTINSBURG, WV 25401					
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) ROSEDALE CEMETERY		Date APRIL 13, 2007	20c. Location - City or Town, State MARTINSBURG, WV		
	21. Signature of Funeral Service Licensee Charles M. Brown			22. Name and Address of Facility BROWN FUNERAL HOME, P.O. BOX 821, 327 W. KING ST., MARTINSBURG, WV 25402					
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter underlying cause (Disease or injury that initiated events resulting in death) Last Septic urinary tract infection Alzheimer's disease							Approximate Interval Between Onset and Death 4 - 5 days	
	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 <input checked="" type="checkbox"/> No 9 □ Unknown								
	23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (Specify) 9 □ Unknown							23d. Date of delivery Month Day Year	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Alzheimer's disease Urinary tract infection Alzheimer's disease							23e. Did tobacco use contribute to the cause of death? 1 □ Yes 2 □ No 3 □ Probably 4 <input checked="" type="checkbox"/> Unknown	
	25. Was case referred to medical examiner? 1 □ Yes 2 <input checked="" type="checkbox"/> No							24a. Was an autopsy performed? 1 □ Yes 2 <input checked="" type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No
Medical Certification: To Be Completed by Physician/Medical Examiner	26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 □ ER/Outpatient 3 □ DOA Other: 4 □ Nursing Home 5 □ Residence 6 □ Other (Specify)								
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 □ Pending investigation 2 □ Accident 6 □ Could not be determined 3 □ Suicide 4 □ Homicide		28a. Date of Injury (Month, Day Year) M		28b. Time of Injury M	28c. Injury at Work? 1 □ Yes 2 □ No	28d. Describe how injury occurred		
	28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)							28f. Location (Street and Number or Rural Route Number, City or Town, State)	
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 □ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
	29b. Signature and title of certifier Dr. Vasant Datta MD							29c. License number D 18019	29d. Date signed (Month, Day, Year) APR 11, 2007
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) VASANT DATTA MD 300 MILL ST HAGERSTOWN MD 21740								
State Registrar	31. Date filed (Month, Day, Year) APR 18 2007			32. Registrar's Signature Leanne L. Jones					

Baltimore, Maryland 21215-0036

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician, page 2 should be detached for use as the burial-transit

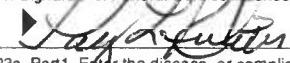
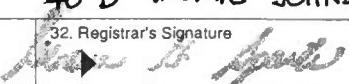
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 12498

1- For State Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Minnie Elizabeth Routzahn							2. Date of Death Month April Day 12 Year 2007	3. Time of Death 6:50 a.m.			
	4a. Facility Name (If not institution, give street and number) 11920 Loy Wolfe Road			4b. City, Town, or Location of Death Myersville			4c. County of Death Frederick					
Funeral Director	5. Social Security Number 217-28-6049	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 88 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	Hours	Min.	8. Date of Birth (Month, Day, Year) Aug. 21, 1918	9. Birthplace (State or Foreign Country) Maryland			
To Be Completed by Funeral Director	Useful Residence of Decedent 10a. State Maryland 10b. County Frederick 10c. City, Town or Location Myersville								10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
	10e. Street and Number 11920 Loy Wolfe Road			10f. Zip Code 21773			10g. Citizen of What Country? USA					
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White				
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 6		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Homemaker		16b. Kind of Business/Industry Own Home							
	17. Father's Name (First, Middle, Last) Ezra Daniel Summers Flook					18. Mother's Name (First, Middle, Maiden Surname) Rosa Gertrude Hoffman						
	19a. Informant's Name/Relationship (Type, Print) Harold Routzahn/son					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7734 Fairplay Road, Boonsboro, Maryland 21713						
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Mt. Zion U. Methodist			Date Apr. 16, 2007	20c. Location - City or Town, State Myersville, Maryland				
	21. Signature of Funeral Service Licensee 					22. Name and Address of Facility Ricketts Funeral Home 504 Main Street Myersville, Maryland 21773						
Physician /Medical Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) PANCREATIC CARCINOMA								Approximate Interval Between Onset and Death 4 MONTHS			
	23b. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last											
	a. Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. _____											
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Unknown			23d. Date of delivery Month Day Year			23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
Medical Certification: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			26. Place of Death (Check only one) <input type="checkbox"/> At home, farm, street, factory, office building, etc. (Specify)						
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)			28b. Time of Injury M			28d. Describe how injury occurred 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29c. License number D 56314			29d. Date signed (Month, Day, Year) APRIL 13 TH 2007						
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BINDU GEORGE 46 B THOMAS JOHNSON DRIVE, FREDERICK MD 21702											
	31. Date filed (Month, Day, Year) APR 18 2007		32. Registrar's Signature 									

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2007 12499
Certificate of Death Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Edna Florence Scanlin						2. Date of Death Month Day Year 3/23/2007	3. Time of Death 1312 p M
	4a. Facility Name (If not institution, give street and number) Anne Arundel Medical Center			4b. City, Town, or Location of Death Annapolis			4c. County of Death Anne Arundel	
Funeral Director	5. Social Security Number 198-07-4973	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 93 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) 11/29/1913	9. Birthplace (State or Foreign Country) PA	
To Be Completed by Funeral Director	10a. State MD			10b. County Anne Arundel	10c. City, Town or Location Edgewater			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	10e. Street and Number 4180 Carvel Lane			10f. Zip Code 21037			10g. Citizen of What Country? USA	
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: Elementary/Secondary (0-12) 12			13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. White
	15. Decedent's Education (Specify only highest grade completed) College (1-4 or 5+)			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Book-keeper			16b. Kind of Business/Industry Publishing	
	17. Father's Name (First, Middle, Last) Edward Scanlin				18. Mother's Name (First, Middle, Maiden Surname) Martha Krupp			
	19a. Informant's Name/Relationship (Type, Print) Ruth Ann Thompson Daughter			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4180 Carvel Lane Edgewater, MD 21037			19c. Date	
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) Boehm Cemetery			20b. Place of Disposition (Name of cemetery, crematory or other place)			20c. Location - City or Town, State Blue Bell, PA	
	21. Signature of Funeral Service Licensee J. J. C. [Signature]			22. Name and Address of Facility Hardesty Funeral Home, P.A. 12 Ridgely Ave. Annapolis, MD 21401				
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Myocardial Infarction Due to (or as a consequence of): b. _____ Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____							
	Approximate Interval Between Onset and Death							
	Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown							
	23c. If yes, outcome pf pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown 3 <input type="checkbox"/> Ectopic pregnancy 5 <input type="checkbox"/> Other (specify) _____							
	23d. Date of delivery Month Day Year							
Medical Certification: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
	23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown							
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No							
	25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No							
	26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) _____							
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide							
	28a. Date of Injury (Month, Day Year) <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA 28b. Time of Injury M 28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No 28d. Describe how injury occurred							
	28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) _____							
	28f. Location (Street and Number or Rural Route Number, City or Town, State) _____							
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
	29b. Signature and title of certifier M. Sanchez M.D.							
	29c. License number D 64089							
	29d. Date signed (Month, Day, Year) 3/23/07							
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mark Sanchez M.D. 2001 Medical Parkway Annapolis Md 21401							
State Registrar	31. Date filed (Month, Day, Year) MAR 26 2007		32. Registrar's Signature [Signature]					

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, The Medical Examiner must be notified at once.

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Hospital or Attend
within 24 hours after death.

**State
Registrar**

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. **2007 12500**

**1 - For
State
Registrar**

Physician /Medical Examiner		<p>1. Decedent's Name (First, Middle, Last) Emma Lou Smith</p> <p>2. Date of Death Month MAR Day 22 Year 2007 3. Time of Death 0905 M</p> <p>4a. Facility Name (If not institution, give street and number) 1183 Bayview Ave.</p> <p>4b. City, Town, or Location of Death Shady Side</p> <p>4c. County of Death Anne Arundel</p>									
Funeral Director		<p>5. Social Security Number 519-26-3240</p> <p>6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F</p> <p>7. Age (In yrs. last birthday) 98 Yrs.</p> <p>If Under 1 Year Months 0 Days 0 Hours 0 Min. 0</p> <p>8. Date of Birth (Month, Day, Year) 9/22/1908</p> <p>9. Birthplace (State or Foreign Country) Idaho</p>									
To Be Completed by Funeral Director		<p>10a. State MD</p> <p>10b. County Anne Arundel</p> <p>10c. City, Town or Location Shady Side</p> <p>10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>10e. Street and Number 1183 Bayview Ave</p> <p>10f. Zip Code 20764</p> <p>10g. Citizen of What Country? USA</p>									
Physician /Medical Examiner		<p>11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced</p> <p>12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: xx</p> <p>13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: White</p> <p>14. Race - American Indian, Black, White, etc. Specify: White</p>									
Medical Certification: To Be Completed by Physician/Medical Examiner		<p>15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11</p> <p>16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Administrative Assistant</p> <p>16b. Kind of Business/Industry Education</p>									
Division or Vital Records, P.O. Box 68760, <p>To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit</p>		<p>17. Father's Name (First, Middle, Last) John Johnson</p> <p>18. Mother's Name (First, Middle, Maiden Surname) Mary Kathryn Wallace</p> <p>19a. Informant's Name/Relationship (Type, Print) Larry Popejoy Grandson</p> <p>19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1183 Bayview Ave. Shady Side, MD 20764</p> <p>20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) ► 3 J.C.</p> <p>20b. Place of Disposition (Name of cemetery, crematory or other place) Metro Crematory</p> <p>Date 3/26/2007</p> <p>20c. Location - City or Town, State Baltimore, MD</p> <p>21. Signatures of Funeral Service Licensee ► 3 J.C.</p> <p>22. Name and Address of Facility Hardesty Funeral Home, P.A. 12 Ridgely Ave. Annapolis, MD 21401</p>									
Medical Certification: To Be Completed by Physician/Medical Examiner		<p>23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.</p> <p>Immediate Cause (Final disease or condition resulting in death)</p> <p>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</p> <p>a. Due to (or as a consequence of): Congestive Heart Failure</p> <p>b. Due to (or as a consequence of): Arteriosclerotic Heart Disease</p> <p>c. Due to (or as a consequence of):</p> <p>d. Due to (or as a consequence of):</p> <p>Approximate Interval Between Onset and Death</p> <p>IF FEMALE:</p> <p>23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown</p> <p>23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown <input type="checkbox"/> Other (specify) 9/22/2007</p> <p>23d. Date of delivery Month 3 Day 26 Year 2007</p> <p>Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Dementia</p> <p>23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown</p> <p>23f. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) ► William P. Jones, MD</p> <p>26. Place of Death (Check only one)</p> <p>27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide</p> <p>28a. Date of Injury (Month, Day, Year) ► 3/26/2007</p> <p>28b. Time of Injury M</p> <p>28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>28d. Describe how injury occurred</p> <p>28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) ► 695 American 21035</p> <p>28f. Location (Street and Number or Rural Route Number, City or Town, State)</p> <p>29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.</p> <p>29b. Signature and title of certifier ► William P. Jones, MD</p> <p>29c. License number D06054</p> <p>29d. Date signed (Month, Day, Year) 3/26/2007</p> <p>30. Name and address of person who completed cause of death (Item 23a) (Type, Print) William P. Jones, MD 695 American 21035</p> <p>31. Date filed (Month, Day, Year) MAR 26 2007</p> <p>32. Registrar's Signature ► William P. Jones, MD</p>									

ORIGINAL